The Relationship between Internalised Homophobia, Sense of Belonging to Specific Communities and Depressive Symptoms among Self-Identified Gay Men

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Statement of Authorship

Except where overt reference is made in the text of this manuscript, this body of work does not include information that has been published elsewhere or been removed in full or part from a thesis by which I have been eligible for or been awarded another degree or diploma. No individual's work has been used without appropriate acknowledgement.

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Abstract

Depression is a major health concern among gay men. This study explored how internalised homophobia and sense of belonging to the general community, the gay community, gay organisations and gay friends influence depressive symptoms in gay men by testing five different models: direct, compensatory, risk-protective, protective-protective and mediation. Two hundred and forty six gay men, aged between 18 and 82 years (M = 35.37, SD = 12.42) were recruited at gay community events. The participants completed self-report measures of internalised homophobia, four spheres of sense of belonging and depressive symptoms. The results indicate that internalised homophobia is a risk factor for depressive symptoms among gay men, whereas sense of belonging to the general community, gay community, gay organisations and gay friends are protective factors. There was support for the compensatory model, but not for the risk-protective and protective-protective models. Finally, there was evidence to support a mediation model, with sense of belonging to gay friends and sense of belonging to the general community partially mediating the relationship between internalised homophobia and depressive symptoms. These results suggest that clinical interventions for depression among gay men should focus on reducing internalised homophobia and increasing sense of belonging to gay friends and the general community in this population.

Chapter 1: Introduction

1.1. Depression

Depression can be either a chronic or a recurrent condition that can significantly reduce an individual's capacity to function on a day-to-day basis (American Psychiatric Association, 2000; World Health Organisation, 2010). People suffering from depression often experience feelings of sadness and guilt and have low self-worth, motivation, interest and energy. These individuals also experience alterations in sleep, psychomotor activity or appetite and a reduction in their ability to concentrate, think and make decisions (American Psychiatric Association, 2000; World Health Organisation, 2010). The New Zealand Mental Health Survey provided evidence that depression often has a significant negative impact on an individual's life (Beautrais, Wells, McGee, & Browne, 2006; Wells et al., 2006a; 2006b). The Participants with some form of mood disorder indicated that the disorder interfered with their life at least moderately (Wells et al., 2006b). Mood disorders wee significantly associated with an increased likelihood of suicidal ideation, plans and attempts. Major Depressive Disorder was the mental disorder associated with the greatest likelihood of an individual having suicidal ideation, attempts, or plans (Beautrais et al., 2006).

Depression is one of the most common mental disorders with an estimated 121 million people suffering from this disorder (World Health Organisation, 2010). It is one of the leading causes of disability worldwide (World Health Organisation, 2010). Depression is expected to increase from being the fourth largest contributor to world wide burden of disease in 2000 to being the second largest in 2020 (World Health Organisation, 2010). The World

Health Organisation (2010) estimated that depression was associated with about 850,000 suicides, worldwide, each year.

Commentators have argued that efforts to prevent depression also need to consider forms of depression that do not meet the criteria for a diagnosis of a depressive disorder (Clarke, Debar, Lynch, & Wisdom, 2003; Gillham, 2003; Parks & Herman, 2003; Le & Munoz, 2003). Psychosocial impairment experienced by individuals with high levels of depressive symptoms, but no diagnosis, is similar to the impairment experienced by those with a diagnosis (Gillham, Shatte, & Reivich, 2001). Westerfield et al. (2001) found among US gay, lesbian and bisexual university students, an association between higher levels of depressive symptoms and fewer reasons to live. These researchers also found, in this sample, an association between higher levels of depression and higher levels of loneliness. Among US university students, there was an association between higher levels of depressive symptoms and lower self-esteem, social connectedness and social competence (Williams & Galliher, 2006). Almost one in three elderly persons living in rural Australia and US experienced depressive symptoms (Buys, Roberto, Miller, & Blieszner, 2008) and about one in five Americans had at least mild depressive symptoms (Shim, Baltrus, Ye, & Rust, 2011).

1.1.1. Depression in Australian Men

Many Australian men experience depression (Australian Bureau of Statistics, 2007a) and it is a major contributor to disease burden for Australian men (World Health Organisation, 2004). The estimated lifetime and 12 month prevalence rates of depressive episodes for Australian men were 8.8% and 3.1% respectively (Australian Bureau of Statistics, 2007a). Approximately twenty

percent of Australian men with an affective disorder suffer from impaired functioning in education or work environments (Australian Bureau of Statistics, 2007a). Additionally, 42.9% of these men had suicidal ideation and 56.3% had suicide plans (Australian Bureau of Statistics, 2007a). The World Health Organisation (2004) estimated that uni-polar depression accounted for 63 disability adjusted life years among Australian men or 629 disability adjusted life years per 100,000 Australian men.

1.1.2. Depression in Gay Men

There is contradictory evidence on whether the sexual orientation of men affects the likelihood of them experiencing depression. Most studies suggest this is the case (e.g., Cochran, Sullivan, & Mays, 2003) whereas some do not (e.g., Gilman et al., 2001) or find mixed evidence (Cochran & Mays, 2000a). Meyer's (2003) meta-analysis of 10 studies indicated that sexual orientation does influence depression prevalence, but this result was based on studies defining sexual orientation in terms of behaviour and self-identification. Rothblum (1994) argued that studying men who have sex with men is different to studying men who identify as gay. Men who have sex with men may not always identify as gay and men who identify as gay may not be sexually active (Rothblum 1994).

It is difficult therefore to compare the results of studies that have investigated the influence of sexual orientation on depression, due to the population of interest being defined in a number of different ways (Cochran & Mays, 2000a; Cochran & Mays, 2000b; Cochran et al., 2003; Gilman et al., 2001; Jorm, Korten, Rogers, Jacomb, & Christensen, 2002; Mays & Cochran, 2001; Meyer, 2003; Mills et al., 2004; Wang, Hausermann, Ajdacic-Gross, Aggleton, & Weiss, 2007; Westefeld, Maples, Buford, & Taylor, 2001). Some

of these studies used sexual identification categories (Cochran et al., 2003; Jorm et al., 2002; Westefeld et al., 2001), other studies categorised sexual behaviour (Cochran & Mays, 2000a; Cochran & Mays, 2000b; Gilman et al., 2001; Mays & Cochran, 2001; Mills et al., 2004) and some used a combination of both (Meyer, 2003; Wang et al., 2007). Some of the studies that failed to find differences in depression prevalence due to sexual orientation (Gilman et al., 2001; Mays & Cochran, 2001) or found mixed evidence of this (Cochran & Mays, 2000a) defined their population based on the sexual behaviour and not the sexual identity of the participants. In this way, they compared men who had sex with men with those that did not have sex with men.

The results of some studies that operationalise sexual orientation based on sexual identity also indicate that gay men do not have higher levels of depression than heterosexual men do (Bybee, Sullivan, Zielonka, & Moes, 2009; Nicholas & Howard, 1998). There was no difference between young Australian heterosexual and gay men in self-reported levels of depression (Nicholas & Howard, 1998). The young gay men, however, had higher levels of suicidal ideation and were more likely to have attempted suicide than young heterosexual men (Nicholas & Howard, 1998). Bybee et al. (2009) found that gay and heterosexual US men had similar levels of guilt, shame and depression. Further analysis of these results revealed that gay men aged 25 and over had lower levels of depression, shame and guilt than younger gay men (Bybee et al., 2009).

In contrast, most studies that operationalise sexual orientation on the basis of sexual identity provide evidence that gay men are more prone to depression than heterosexual men (Biernbaum & Ruscio, 2004; Cochran & Mays, 2009, Cochran et al., 2003; Jorm et al., 2002; King, et al., 2008; Westefeld

et al., 2001). An Australian study comparing gay, lesbian, bisexual and heterosexual adults, in a random community sample, found that when controlling for age and gender, gay men, lesbians and bisexuals had significantly higher levels of depression, anxiety, suicidal thoughts or behaviours and negative affect than heterosexuals (Jorm et al., 2002). In addition, bisexuals were significantly higher on all mental health indices, except suicidal thoughts or behaviour, than gay men or lesbians (Jorm et al., 2002). Gay men, lesbians and bisexuals in the US, were more likely to be depressed, lonely and have fewer reasons for living than heterosexuals (Westefeld et al., 2001). Biernbaum and Ruscio (2004) in their matched pair design study found that the American gay, lesbian and bisexual participants had significantly higher levels of depressive symptoms than the heterosexual participants. Finally, US university students who identified as gay, lesbian, bisexual, transgender or unsure were found to be significantly more likely to experience or be diagnosed with depression than heterosexuals (Lindsey, Fabiano, & Stark, 2009).

The results of 12-month prevalence studies indicated that men who identify as gay or bisexual have poorer mental health than heterosexual men (Cochran & Mays, 2009; Cochran et al., 2003). US men who identified as either bisexual or gay were three times more likely than those identifying as heterosexual to have Major Depressive Disorder in the previous year (Cochran et al., 2003). Gay and bisexual men were almost four times more likely than heterosexual men to have had Major Depressive Disorder and have a comorbid disorder and almost three times more likely to have had any mental disorder (Cochran et al., 2003). Another study found that the prevalence rate for Major Depression among US gay men was 21.5% (Cochran & Mays, 2009). This 12

month prevalence rate was higher than bi-sexual men (15.7%) and exclusively heterosexual men (8.7%), but lower than homosexually experienced heterosexual men (30.7%; Cochran & Mays, 2009). These researchers estimated that if the risk level for depression among sexual minority men were reduced to that of exclusively heterosexual men, there would be a 15% reduction in the morbidity of Major Depression among men (Cochran & Mays, 2009).

A meta-analysis of various prevalence studies that defined sexual orientation by self-identification (King, et al., 2008), provided evidence that gay men have poorer mental health outcomes than heterosexual men. This study found that lesbian, gay and bisexual adults were twice as likely to complete suicide within the previous 12 months and four times more likely to complete suicide over the course of a lifetime than heterosexual people. This study also found that lesbian, gay and bisexual men were 1.5 times more likely to have depressive and anxiety symptoms and to abuse substances than heterosexuals.

Although there is a general trend in most of these studies that gay men have a higher prevalence of depression than heterosexual men (Biernbaum & Ruscio, 2004; Cochran et al., 2003; Cochran & Mays, 2009; Jorm et al., 2002; Lindsey et al., 2009; Westefeld et al., 2001), it is difficult to compare the results of these studies for a number reasons. In general, it is difficult to compare prevalence studies, as more than the actual level of morbidity found within the population of interest can lead to differences in the prevalence reported, such as differences in the measurement method, response rate and the way a disorder is defined (Wells et al., 2006b). Moreover, in the large random population based surveys (e.g., Cochran et al., 2003), those identifying as gay only make up a small percentage of the sample with the comparison group making up far greater

proportion of the sample. This small size of one of the groups may lead to some comparisons not reaching significance (Cochran et al., 2003).

Additionally, the studies reviewed differed in the age composition of the sample (e.g., Bybee et al., 2009; Cochran et al., 2003; Lindsey et al., 2009) and some studies did not account for gender differences in prevalence rate (e.g., Biernbaum & Ruscio, 2004). Some studies used samples with a restricted age range. Jorm et al. (2002) only recruited participants in the 20-24 and 40-44 age ranges, Nicholas and Howard (1998) used a sample with a mean age of 20.59 years and Bybee et al. (2009) recruited participants aged 18-48 years. The remainder of the studies used samples of college students (Biernbaum & Ruscio, 2004; Lindsey et al., 2009; Westefeld et al., 2001) or recruited adult community samples of all ages (Cochran et al., 2003; Cochran & Mays, 2009). The age composition of the sample is important as the prevalence of depression declines with age (Wells et al., 2006a; Wells et al., 2006b). Moreover, one study demonstrated that this age related pattern occurred among gay men (Bybee et al., 2009). Similarly, four studies (Biernbaum & Ruscio, 2004; King, et al., 2008; Lindsey et al., 2009; Westefeld et al., 2001) did not distinguish between men and women, but there are gender differences in the prevalence of depression (American Psychiatric Association, 2000; Australian Bureau of Statistics, 2007a).

The studies also differed in the length of time that they calculated the prevalence rate for (e.g., Bybee et al., 2009; Cochran et al., 2003) and how they measured depression (e.g., Biernbaum & Ruscio, 2004; Cochran & Mays, 2009). Three of these studies (Cochran et al., 2003; Cochran & Mays, 2009; Lindsey et al., 2009) investigated the 12-month prevalence rate whereas the others measured

the current level of symptoms (Biernbaum & Ruscio, 2004; Bybee et al., 2009; Jorm et al., 2002; Nicholas & Howard, 1998; Westefeld et al., 2001). The different time frames would mean that many of those individuals counted as having depression in 12-month prevalence studies would be excluded from studies investigating current levels of symptoms. Finally some of these studies measured depression based on the presence of a diagnosis (Cochran et al., 2003; Cochran & Mays, 2009), while others measured depressive symptoms (Biernbaum & Ruscio, 2004; Bybee et al., 2009; Jorm et al., 2002; Nicholas & Howard, 1998; Westefeld et al., 2001). One study (Lindsey et al., 2009) measured both symptoms and a diagnosis of depression. The presence of depressive symptoms does not mean that an individual meets the diagnostic criteria of a Mood Disorder (American Psychiatric Association, 2000). Therefore, studies that measure depressive symptoms would count individuals who do not meet the criteria for a disorder as being depressed, unlike a study defining depression by the presence of a diagnosis.

In summary, differences in study design make comparison between studies difficult (Wells et al., 2006b). The results of most studies reviewed, however, in which sexual identity was used to define sexual orientation, indicated that gay men are more prone to depression than heterosexual men. Additionally, these studies provided evidence that a large number of gay men are depressed. The 12-month prevalence for major depression, for US gay or bisexual men, was given by various studies as between 10% and 31% (Cochran & Mays, 2009; Cochran et al., 2003). In comparison, a lower 12-month prevalence rate of between 5.1 and 10.2% has been found in the US by various studies for heterosexual men or men who only had sex with women (Cochran &

Mays, 2009; Cochran et al., 2003). Finally, one study found that the average level of depressive symptoms, among gay men, lesbians and bisexuals, was rated as indicating mild depression (Westefeld et al., 2001).

1.2. Risk and Protective Factors for Depression among Gay Men

In order to understand why gay men may be more prone to depression, there is a need to identify risk and protective factors that affect their mental health. Risk factors are the characteristics of an individual or their environment (Munoz, Mrazek, & Haggerty, 1996; Reiss & Price, 1996) that increase their likelihood of developing a mental disorder, as well as increasing both the symptom severity and duration (Coie et al., 1993; Munoz et al., 1996; Reiss & Price, 1996). In contrast, protective factors are variables that allow the individual to cope with either the risk factor or the development of a mental disorder (Coie et al., 1993; Reiss & Price, 1996). Identifying risk and protective factors and any interaction between these variables may explain why some individuals experience more maladjustment than others, when exposed to the same risk factor (Luther, Cicchetti, & Becker, 2000). By identifying risk factors, researchers are able to identify populations that have an increased risk of developing a specific mental disorder (Gillham, 2003). Moreover, being gay may be associated with the development of risk and protective factors affecting mental health that are unique to this population (Meyer, 2001; Rothblum, 1994; Waldo,1999) and these factors may interact in unique ways for this population (Rothblum, 1994).

1.2.1. Risk Factor

Internalised homophobia or *internalised homonegativity* is the extent to which a homosexual individual has internalised society's negative perception of

homosexual identification, sexual attraction, and/or behaviour, so that they have negative feelings and attitudes towards their own homosexuality and that of others (Balsam & Mohr, 2007; Igartua et al., 2003; Meyer, 1995; Ratti et al., 2000; Shidlo, 1994). Alternatively, internalised homophobia is often defined more simply as how comfortable a gay man is with being gay (Igartua et al., 2003; Williamson, 2000). Internalised homophobia may be useful in identifying at risk individuals (Williamson, 2000).

1.2.1.1. Conceptualising Anti-Gay Prejudice and Discrimination

The term *homophobia* is often used to explain the prejudice and discrimination that gay men face in the community (Johnson & Johnson, 2001). Homophobia was originally defined as a fear of being around or near gay men (Weinberg, 1972) and it represented an effort to shift the focus in explanations of the mental health of gay men from their same-sex attraction to the way they were treated by society (Herek, 2000b; Tomsen, 2006). Over time, it has been defined more broadly as fearing or disliking gay men (Blumenfeld & Raymond, 1988; Johnson & Johnson, 2001; Tomsen, 2006) or fearing being called homosexual (Blumenfeld & Raymond, 1988). The term homophobia has been criticised as it presents prejudice towards gay men as being caused by a fear of gay men rather than caused by the individual's possession of anti-gay cognitions (Williamson, 2000). The term also suggests that this prejudice is defensive in nature rather than being a reflection of the prejudiced individual's values (Shidlo, 1994) and that this prejudice is due to the individual that expresses it rather than society (Herek, 2000a; Tomsen, 2006; van der Meer, 2003; Williamson, 2000). Additionally, the term has been applied to describe a wide variety of behaviours and thoughts including negative attitudes towards gay men (Green, 2005), acts of

harassment (Tomsen, 2006) and violence (Green, 2005; Tomsen, 2006), so that it has become a catchphrase (Green, 2005).

Due to these criticisms of the term homophobia, alternative terms have been proposed (Igartua, Gill, & Montoro, 2003; Johnson & Johnson, 2001; Shidlo, 1994; Tharinger & Wells, 2000; Williamson, 2000). Others have proposed the term *homonegativism* (Mayfield, 2001; Shidlo, 1994; Williamson, 2000), which is more focused on the beliefs and values of those prejudiced towards gay men (Mayfield, 2001, Williamson, 2000). Alternatively, the term *heterosexism* has been coined to explain why certain heterosexuals develop prejudicial beliefs and behaviours towards gay men (Tharinger & Wells, 2000), as well as a fear of gay men (Johnson & Johnson, 2001). Heterosexism is defined as the belief that heterosexuality is both the superior and natural form of sexuality (Herek, 1990; Igartua et al., 2003; Johnson & Johnson, 2001; Waldo, 1999, Williamson, 2000) and that societal structure and cultural values maintain these beliefs within society (Igartua et al., 2003; Johnson & Johnson, 2001). The use of the term of heterosexism not only allows greater focus on the structures that allow and maintain prejudice against gay men, but it also allows for parallels to other forms of discrimination (Tomsen, 2006).

An increasing number of studies have explored how homophobia or heterosexism has changed over time (Massey, 2009; Walls, 2008). Recent researchers have suggested that heterosexism is a multifaceted construct that has changed over time to become more subtle and less overt (Cowan, Heiple, Marquez, Katchadourian, & McNevin, 2005; Massey, 2009; Walls, 2008). Some of these researchers have attempted to develop new measures or taxonomies that

capture the multifaceted aspects of modern heterosexim (Green, 2005; Massey, 2009; Walls, 2008).

There has also been recent research exploring how modern heterosexism leads to different patterns of discrimination than more traditional forms of heterosexism (e.g., Cowan et al., 2005). Cowan et al. defined traditional heterosexism as being characterised by a direct and overt hostility towards gay men and lesbians. In contrast, modern heterosexism was characterised by denying that gay men and lesbians are discriminated against and arguing that there is no need to increase the rights of gay men and lesbians. Therefore, a modern heterosexist would agree that gay men have a right to be in a long-term committed relationship, but argue in terms of traditional values that rights associated with marriage should be denied to gay men. Cowan et al. found that among US university students, there was a strong association between traditional heterosexism and approval of hate crimes and minimising the harm and offensiveness of hate speech. Although modern heterosexism was not as strongly associated with approval of hate crimes, a positive association still existed and there was also a strong correlation between this form of heterosexism and minimising harm and offensiveness of hate speech. When traditional heterosexism was controlled for, modern heterosexism only predicted minimising harm of hate speech. The results of this study suggested that modern heterosexism was simply the covert expression of traditional heterosexism.

Herek (2000a) proposed another term for homophobia, *sexual prejudice*, which he defined as having negative attitudes towards a particular form of sexual orientation. Due to the current social standards, Herek suggested that sexual prejudice invariably describes the negative attitudes that heterosexuals have

towards same-sex sexual interaction and attraction, identifying as gay, lesbian or bisexual and the communities formed based on these sexual identities. Sexual prejudice is like any other form of prejudice in that a specific social group is being negatively evaluated or judged (Herek, 2000a). Herek argued that conceptualising anti-gay attitudes, as a prejudice is advantageous, as it does not make any assumptions about what motivates these attitudes or how they originate. This conceptualisation does not require the presentation of anti-gay attitudes as being either irrational or evil, as the term is purely descriptive rather than judgemental (Herek, 2000a).

1.2.1.2. Western Culture and Sexual Identity

The traditional view of gay men in Western society is culturally determined (Herek, 1986, 1990; Tomsen, 2006; Walls, 2008). Cross-cultural studies support the notion that sexual identities are cultural constructs, rather than biological facts, as other non-western cultures have alternative beliefs and responses to sexual behaviours and roles (Herek, 1986). It was not until the late nineteenth century that sexuality became culturally important in Western society (Herek, 1990; Tomsen, 2006). From this period onwards, sexual behaviour was used to categorise people in a way that defined their roles and identity, creating the categories of heterosexuality and homosexuality (Herek, 1986, 1990; Tomsen, 2006). The use of observable categories of heterosexuality and homosexuality to describe sexual practices and desires developed in Western culture, despite the traditional cultural expectation to keep sexual behaviour private (Herek, 1990; Mason, 2001). The sexual behaviour of gay men is stigmatised in Western culture, in part, due to it not being sanctioned by marriage and not being reproductive in nature, which violates cultural rules about sexuality

(Herek, 1990). Because of this stigmatisation, men engaging in gay sex were traditionally considered deviant or abnormal and pursuing sex merely for pleasure (Herek, 1990).

By recognising oneself in terms of a sexual identity, the individual is taking on the responsibility of monitoring and regulating their behaviour to conform to the expectations associated with the sexual identity that they assume (Mason, 2001). As Western culture considers heterosexuality as normative, there are very few negative consequences to openly identifying as heterosexual (Mason, 2001). In contrast homosexuality was considered a mental disorder from the late nineteenth century until 1973, when the American Psychiatric Society decided to no longer classify it as such (Cabaj, 2009; Green, 2005; Herek, 1990; Lucies & Yick, 2007; Mayfield, 2001). As homosexuality is traditionally not seen as normal, historically there have been negative consequences for publicly identifying as gay (Mason, 2001). Despite the increasing public exposure of homosexuality in law, media, politics and culture, there continues to be censorship into what aspects of homosexuality are displayed publicly (Mason, 2001). Due to the traditional negative view of homosexuality, before a gay man can openly acknowledge their sexual identity to another person, they must weigh up the costs and benefits of doing so (Mason, 2001). As gay men are often selective about whom they come out to, most heterosexuals are unaware that they are interacting with a gay man (Herek, 1990). Consequently, their perception of gay men is largely informed by culture rather than knowingly interacting with gay men (Herek, 1990).

Since the early 1970's gay men have become an increasingly more visible part of the wider community, due to an active campaign for social equality

(Herek, 1986, 1990; Szymanski, Kashubeck-West, & Meyer, 2008a). Additionally, the AIDS epidemic drew greater media coverage to the gay community and relationships between gay men (Herek, 1990). As gay men were depicted caring for ill lovers and friends, this media attention demonstrated that relationships between gay men could include socially desirable qualities, such as commitment and self-sacrifice (Herek, 1990). Due to the influence of civil liberties campaigning, being gay has publicly become increasingly associated with community membership and committed relationships, in addition to sexual behaviour (Herek, 1990).

Gornan-Murray, Waitt and Gibson's (2008) qualitative study demonstrates the extent to which the community embraces diversity in sexual identity depends on circumstances. This study investigated the level of acceptance of gay men and lesbians in the rural Victorian town of Daylesford, a locality that has a reputation for being accepting of gay men and lesbians. Gornan-Murray et al. found that there were limits to the acceptance of gay men and lesbians in this town. Daylesford hosts the Chill-Out festival, which is the largest gay and lesbian festival hosted in Australia outside a metropolitan centre. Some shops openly display the rainbow flag, which represents the gay and lesbian community. The community backlash to attempts to have a rainbow flag flown from the Daylesford town hall is described by Gornan-Murray et al. They argued that this local debate demonstrated that even in localities where there is a general acceptance of gay and lesbian festivals and symbols; this does not mean that the wider community is necessarily accepting of the gay and lesbian community or tolerant of this community. To Gornan-Murray et al., this debate was a microcosmic example of what was happening in Australia. These

researchers argued that despite “drag queens” performing at the closing ceremony of the Sydney Olympics and the promotion of the Gay and Lesbian Mardi Gras Parade gay men are still discriminated against.

1.2.1.3. Legal Discrimination against Gay Men

Past and current laws that discriminate against gay men demonstrate the lack of acceptance of sexual diversity that has existed in Australian society (Bull, Pinto, & Wilson, 1991; Herek, 1990; Millbank, 2006a, 2006b). The view of gay sex as “sick”, “perverse”, “dangerous” or “corrupt” was used to justify the criminalisation of consensual sex between two men (Bull et al., 1991; Herek, 1990; Kirby, 2005) in Australia from the time of settlement until towards the end of the twentieth century (Bull et al., 1991; Kirby, 2005). Some members of the community opposed the decriminalisation of these laws, as they claimed that these laws prevented the spread of AIDS (Bull et al., 1991). Until the occurrence of decriminalisation, gay sex was considered a serious crime (Bull et al., 1991). For example in Victoria those convicted, prior to 1980, could face up to 20 years in jail (Bull et al., 1991). South Australia was the first Australian state or territory to decriminalise consensual gay sex, in private, in 1972 (Bull et al., 1991), and Tasmania was the last jurisdiction where this decriminalisation occurred, in 1994 (Kirby, 2005).

Despite these positive legal changes in Australia, gay men are still discriminated against in non-criminal law (Kirby, 2005; Millbank, 2006a; 2006b). Millbank (2006a), in her review of Australian laws regarding couples, described legislative changes introduced by various state and territory governments, since 1999. These changes to state and territory law gave co-habiting same-sex couples, the same rights as heterosexual defacto couples.

Federal law, according to Millbank, at that time did not recognise co-habiting same-sex couples, as defacto couples. This commentator argued that traditionally federal law discriminated against same-sex couples by not acknowledging them in certain legislation. Only recently, Millbank contends that this situation has worsened, with legislation passed by Federal Parliament that explicitly excluded same-sex couples from certain rights. For example, a recent amendment of federal marriage law, now defines marriage as being exclusively between a man and a woman (Australian Federal Parliament, 2004). Additionally, Millbank (2006b) described how gay men are also discriminated against in laws governing fertility and adoption. According to Millbank, federal and state legislation prevent men who declare themselves as engaging in same-sex intercourse from being sperm donors. This review of adoption laws revealed that only Western Australia and the Australian Capital Territory grant gay men the same adoption rights as heterosexuals. The only other state that allows a gay couple to be legally recognised as joint parents of a child is Tasmania, where a gay man is legally able to adopt the biological child of their same-sex partner.

1.2.1.4. Anti-Gay Discrimination

G ay men are also exposed to discrimination in housing, aged-care and in everyday life (Jackson, Johnson, & Roberts, 2008; Johnson, Jackson, Arnette, & Koffman, 2005; Page, 1998; Swim, Pearson, & Johnston, 2007). In the US and Canada when a caller inquiring about rental accommodation indicated that they were gay or lesbian they were significantly more likely to be told that a room was not available than told that one was available (Page, 1998). Herek (2009) found that 17.7% of gay men in the US experienced discrimination in employment or housing, due to sexual orientation. Gay men and lesbians were

more likely to report discrimination than bisexuals were. Herek concluded that these differences were probably due to gay men and lesbians being more visible than bisexuals, due to residing with a same-sex partner and being more open about their sexuality. Additionally, Herek found that slightly more than half of the participants believed that most people would think less of gay, lesbian or bisexual individuals and would be less likely to hire or trust these sexual-minorities with looking after children.

Two questionnaire studies explored the beliefs and attitudes of US adults towards aged-care for gay, lesbian, bisexual and trans-sexual elderly (Jackson et al., 2008; Johnson et al., 2005). Jackson et al. (2008) found that there was no difference between heterosexuals and sexual minority men and women in the belief that discrimination on the basis of sexual orientation occurred in aged care facilities and that there was a need for staff to be trained to be more sensitive to sexual orientation. They found that most of the gay, lesbian, bisexual and transgender participants believed that they do not have equal access to social and health services whereas most of the heterosexual participants believed the opposite. The majority of both groups favoured gay, lesbian, bisexual and transgender exclusive or friendly retirement homes, but a greater proportion of gay, lesbian, bisexual and transgender respondents favoured this. In addition, more gay, lesbian, bisexual and transgender than heterosexual individuals believed that sensitivity training would increase tolerance among staff and residents at these retirement homes. Another study using gay, lesbian, bisexual and transgender participants found that the majority believed that discrimination occurred in aged care facilities and that gay, lesbian, bisexual and transgender friendly retirement homes were required (Johnson et al., 2005).

Swim et al. (2007) followed the daily discrimination in the US experienced by gay men, lesbian and bisexual participants using a diary. They found that daily discrimination tended to involve verbal comments that contained stereotypes of sexual minorities or hostile remarks about this population. There were no gender stereotypes, however, in these remarks. Additionally, they found that this daily discrimination could also involve refusal of service. They also found that the responses of these participants indicated that they feared discrimination could occur and that this had an impact on their daily functioning. The degree that a participant was out did not affect the number of heterosexist events that were reported, but the nature of the events was related to being out. For example, those less out observed heterosexist behaviour not directed at them whereas those more out tended to experience more events directed at them. They found that those that were less out were less exposed to receiving poor service, but were also more fearful of experiencing heterosexism than those who were more open about their sexuality.

1.2.1.5. The Social Alienation of Gay Men

Gay men can feel alienated in everyday life from the rest of the community by heterosexist language and behaviour (Burn, Kadlec, & Rexer, 2005; Oswald, 2001, 2002; Smith & Ingram, 2004). Burn et al. (2005) presented US gay, lesbian and bisexual students with 13 sentences that described heterosexist language or assumptions being used by heterosexuals to deride another person. This study provided evidence that heterosexist remarks offended gay men even when not directed at them. They also found that gay men tended to be less offended than either lesbians or bisexuals. Additionally, they found

that there was a weak association between being offended by these remarks and coming out to these people.

The experience of heterosexism in the workplace can adversely affects gay men (Smith & Ingram, 2004; Waldo, 1999). Smith and Ingram (2004) investigated the effects of heterosexism in the workplace on lesbians, bisexuals, and gay men. These researchers found that those who experienced heterosexism at work were more likely to be depressed and to experience psychological distress than those who did not have this experience. Waldo (1999) found that lesbians, bisexuals, and gay men employed in workplaces that tolerated heterosexism were more likely to experience heterosexism than lesbians, bisexuals, and gay men did in workplaces that did not tolerate heterosexism. This study also found that lesbian, bisexual, and gay men employed in work places with a higher proportion of male workers were more likely to experience heterosexism than workplaces with a lower proportion of men. The experience of heterosexism was also associated, in this sample, with higher levels of psychological distress.

Gay men can feel alienated when attending heterosexual rituals, such as marriages (Oswald, 2001, 2002). A qualitative study of gay, lesbian, bisexual and transgender individuals in the US (Oswald, 2001) found that when attending heterosexual weddings, these individuals tended to feel like outsiders. The analysis of interview responses found that these participants developed this perception as people they encountered at weddings related to them as if they were heterosexual or, in contrast, would turn away from them. These participants also reported that they found the religious content of the wedding ceremony discriminatory, so that they actively distanced themselves from this

content and justified this via criticisms of the ritual. Another study (Oswald, 2002) found that gay men and lesbians in the US were more likely to be invited to weddings if their immediate family were supportive of them. The partners of these gay men and lesbian participants were more likely to be invited if it was widely known within the extended family that that person was gay or lesbian. The inviting of the gay or lesbian partner was also found to be predicted by how open this couple was about their relationship. In addition, when partners are invited, the support from the immediate family most strongly predicted the level of inclusion that these participants felt. When the partner was not invited, support from the extended family was more important in predicting how included that they felt.

1.2.1.6. Mental Health Consequences of Anti-Gay Discrimination

The negative way that gay men are treated by the society in which they live undermines the mental health of this population (de Graaf, Sandfort, & ten Have, 2006; Mays & Cochran, 2001; Rogers, 2007). Rogers identified the most pressing concerns perceived to undermine health among Australian gay, lesbian, bi-sexual, transgender and inter-gender individuals. These concerns were in descending order, discrimination under the law and in daily life, homophobic views in the media, feeling excluded from the general community and hearing homophobic comments. According to Mays and Cochran (2001), gay and bisexual men, in the US, were twice more likely to experience perceived discrimination during their lifetime than heterosexuals. Slightly less than half of the gay and bisexual men they surveyed perceived their sexual orientation as either part or the sole cause of this discrimination. Moreover, gay and bisexual men were approximately 33 times more likely to attribute the experience of

discrimination to sexual orientation than heterosexuals. Gay and bisexual men were about twice more likely to experience daily-perceived discrimination than heterosexuals. When demographic differences between the groups were controlled for so that they only differed on sexual orientation, those who experienced discrimination at least once during their lifetime were 1.6 times more likely to be diagnosed with at least one mental disorder than those that did not. Additionally, those who experienced daily discrimination were 2.13 times more likely than those that did not to experience a mental disorder.

Another group of researchers using the results of a large population survey (Hatzenbuehler, Keyes, & Hasin, 2009) found an association between state laws and the mental health of gay men, lesbians and bisexuals. Members of these populations living in US states that did not have specific laws outlawing sexual orientation hate crimes and discrimination reported a higher 12-month prevalence rate of mental disorders, including depression, than those living in states that had these laws. A study of self-identified gay men in the US found that there was a positive correlation between perceived discrimination and depressive symptoms (Zakalik & Wei, 2006). Szymanski (2009) found that the experience of harassment, discrimination and rejection because of sexual orientation affected the mental health of gay and bisexual men. This association was found even when the researcher controlled for other predictors of psychological distress self-esteem, social support and avoidant coping. Similar results have been found for men who have sex with men (de Graaf et al., 2006). A population-based study in the Netherlands found that men who had recently had sex with men and had a perceived experience of discrimination were more likely to have death wishes, contemplate suicide, deliberately self-harmed and

more suicidal tendencies than men who had not had sex recently with other men (de Graaf et al., 2006).

1.2.1.7. Prevalence of Anti-Gay Attitudes

It is evident that the main reason that gay men experience overt discrimination is the large proportion of the general community holding negative attitudes towards their sexual orientation (Anderson & Hellesund, 2009; Flood & Hamilton, 2005; Kelley, 2001; Moskowitz, Rieger, & Roloff, 2010; Nierman, Thompson, Bryan, & Mahaffey, 2007; Schellenberg, Hirt, & Sears, 1999; Yang, 1997). Higher levels of homophobic attitudes have been found to influence people's attitudes to gay and lesbian parents in Norway (Anderson & Hellesund, 2009) and same-sex marriage in the US (Moskowitz et al., 2010). Yang found that many of those surveyed in the US disapproved of homosexual behaviour and those that engaged in this behaviour, with about one in two considering homosexual behaviour wrong. Although most of this sample was opposed to gay marriages and adoption by same-sex couples, most accepted the need to protect the civil rights of gay men. Additionally, most of the participants in this study supported some recognition of same-sex partners, such as allowing them access to their partner's employee health benefits. According to Flood and Hamilton (2005), 35% of Australians surveyed, aged from 14 years old, considered homosexuality immoral. The results of this survey also indicated that negative views about homosexuality were more common among men than among women, with 43% of the former considering homosexuality immoral compared to 27% of the latter.

Kelley (2001) found that 28% of Australians did not think homosexuality was wrong in any way, whereas 48% said that it was always wrong. The

remainder of the sample reported that homosexuality was either almost always wrong or sometimes wrong, with 9% and 15% endorsing these responses respectively. The distribution of this data were bi-modal suggesting that the sample were polarised on this issue, with the majority either accepting or rejecting homosexual behaviour, with very few people in between. Additionally, Kelley compared his results to those found in similar studies conducted in 29 other countries. According to his results Australia was as tolerant to homosexuality as three other countries, including Great Britain; was significantly more tolerant than 14 others, including the US and Russia; and less tolerant than 11 countries, including France and the Netherlands. However, in all these countries, homosexuality was not accepted and the intolerance in these countries only varied in its level of intensity. In all of these countries, women were more tolerant of homosexuality than men.

Additional evidence supporting a greater amount of prejudice against gay men among men than among women is found in studies exploring attitudes towards gay men in the US, Chile and Ireland (Cowan et al., 2005; Morrison, Speakman, & Ryan, 2009; Nierman et al., 2007). Cowan et al. (2005) found that US men were more inclined to support the open expression of anti-gay or lesbian beliefs and more supportive of hate crimes against gay men and lesbians than women were. Additionally, women perceived a greater level of harm being caused by anti-gay or lesbian speech than men did. In Ireland, male university students were less supportive of the civil rights and freedom of expression of gay men and lesbians than women were (Morrison et al., 2009). Men were also found to hold more prejudiced views towards gay men and lesbians, especially towards the former, than women in both the US and Chile (Nierman et al., 2007).

1.2.1.8. The Greater Intolerance of Gay Men

A number of studies have found that in addition to heterosexual men being more intolerant of gay men than heterosexual women are, heterosexuals are more intolerant of gay men than they are of lesbians (Herek, 2000b, 2002 Massey, 2009; Moskowitz et al., 2010; Nierman et al., 2007; Schellenberg et al., 1999). Men studying at a Canadian university had more negative attitudes towards gay men than women did and that both men and women had more negative attitudes towards gay men than they did towards lesbians (Schellenberg et al., 1999). Both men and women completing undergraduate courses at a US university were more prejudiced towards gay men than they were towards lesbians (Massey, 2009). Similarly, among US undergraduates, men tended to be more negative towards same-sex marriage than women were and that unlike women, men were more favourable towards marriage between two women than two men (Moskowitz et al., 2010). US population surveys (Herek, 2000b, 2002) have found that men and women differed in their attitudes and emotional responses towards gay men and lesbians in several ways. Herek (2000b) presented data gathered from several earlier population surveys that demonstrated that the attitudes of heterosexual men towards gay men were more hostile than their attitude towards lesbians. Additionally, their attitudes towards gay men were more hostile than the attitude of heterosexual women towards either lesbians or gay men. Additionally, Herek (2002) presented data from a random telephone survey in the US that replicated the results of the population surveys. The women in this study were found to be more supportive of the civil rights of gay men and lesbians, had less stereotypical views and less affective reactions to gay man and lesbians than the men did (Herek, 2002). Although

Herek found that heterosexuals were more negative attitudes towards homosexuality among their own sex, this pattern was far stronger for men than it was for women.

The results of the various US population surveys presented by Herek (2000b, 2002) indicate that gay men can provoke stronger reactions than lesbians among heterosexuals. This research found that when heterosexual men were asked questions about gay men first, they gave responses towards lesbians that were more negative than when they were asked about gay men second. This pattern was not apparent in the response of the female participants. This result suggests that heterosexual men have more fully formed ideas about gay men than they do about lesbians (Herek, 2000b, 2002). Attitudes towards gay men and lesbians were highly correlated for both heterosexual men and women (Herek, 2000b). These researchers also found that both men and women had more negative affective reactions towards gay men than they did towards lesbians. Moreover, gay men were more likely to be perceived as mentally ill and paedophiles than lesbians were and there was more support for adoption rights for the latter than the former (Herek, 2002).

The results of Mahaffey, Bryan, and Hutchison's (2005) experiment indicate that gay men provoke a stronger reaction than lesbians among heterosexual men than lesbians do. This study involved exposing US university students to homoerotic images and measuring their startle response by electrodes placed under their left lower eyelid. Both sexes showed greater startle response towards images of gay couples than either lesbian or heterosexual couples. They found that both men and women expressed more discomfort around homosexuality of a same-sex rather than opposite sex person. The magnitude of

this difference in this expression of discomfort was greater among men than it was among women. Moreover, regression analysis demonstrated that it was only among men that gender and anti-gay bias, as well as an interaction between these variables, predicted the physiological response to images of gay men.

1.2.1.9. Gender Role and Identity in Anti-gay Attitudes

Herek (2002, 2000b, 1986) proposes that the reason that there are more hostile attitudes towards gay men than lesbians, especially among heterosexual men, is due to gender identity or role issues. Homosexuality, in Western society, is considered to violate gender norms, unlike heterosexuality, which is considered to fit with these cultural expectations (Herek, 1990). Gay men have historically been discriminated against due to both their sexual behaviours and their perceived violation of expected gender roles (Herek, 1990). Heterosexual masculinity is defined in Western culture as being characterised by such traits as toughness, independence and aggressiveness (Herek, 1986). It is also defined by not being effeminate and not being homosexual (Herek, 1986, 1990) and many people perceive gay men as being more effeminate than heterosexual men (Herek, 2000b). Moreover, men who are not seen as conforming to gender role expectations are often branded gay, regardless of their actual sexual orientation (Herek, 1986).

There is evidence that traditional views of gender norms are linked to prejudicial views against gay men (Whitley, 2001). Two meta-analysis studies (Whitley, 2001) found that an adherence to traditional beliefs about gender roles was both associated with and predicted anti-gay attitudes in both men and women. Traditional gender role beliefs were only associated and predicted anti-gay behaviours in men, not women. They also found that hyper-masculinity, a

strong belief in the traditional male gender role, was strongly associated with both anti-gay behaviour and attitudes.

In Western society, attitudes towards gender roles and sexuality are developed through social institutions and interactions (Ehrlich, 1990; Herek, 1986; Walls, 2008). The sexual identities of heterosexuality and homosexuality develop through a man's participation in social organisations and social interaction, such as schooling and family (Ehrlich, 1990; Herek, 1986). Parents communicate traditional sex-role attitudes to their children while teaching and modelling other behaviour (Ehrlich, 1990). In this way, men are brought up in Western society to accept roles attributed to their biological sex, so that they accept the cultural beliefs, values and customs surrounding masculinity as being normal (Herek, 1990). Gay men when growing up are exposed to the same sexual orientation attitudes as heterosexual men are, so that they are aware of the attitudes that exist towards their sexuality (Walls, 2008).

Jellison, McConnell, and Gabriel (2004) conducted two studies exploring the relationship between attitudes towards sexual orientation and the individual's actual sexual orientation. They measured implicit attitudes by presenting participants with a series of pictures of couples, so that the participants could then decide if the men in the images were gay or straight and if a positive or negative adjective best described the picture. Explicit attitudes were measured by participants completing a questionnaire directly asking them about their attitudes towards heterosexuality and homosexuality. These researchers found that both gay and straight men favoured their own sexual orientation over the other and that explicit and implicit attitudes were significantly correlated with each other. They also found that for gay men, explicit attitudes towards

homosexuality predicted how open they were about their sexuality, whereas implicit attitudes predicted how much they participated in gay culture. Finally, they found that there was a positive correlation for gay men between attitudes towards homosexuality and heterosexuality, but a negative correlation between these attitudes in straight men. They also found negative correlations for heterosexual men between their attitudes towards gay men and the importance of heterosexuality and adherence to traditional male sex roles. Among straight men, there were also positive correlations between having a more positive attitude towards straight men than towards gay men and the importance of being straight and adhering to a male sex role. Finally, they found that there was no correlation between social desirability and the attitudes of straight men towards gay men.

1.2.1.10. Masculinity and Anti-Gay Violence

The results of Jellison et al. (2004) study provide evidence that heterosexual identity in men is associated with a positive attitude towards traditional gender roles and a negative attitude towards homosexuality. In the last few decades, however, gay men have become more socially visible, a trend that has increased the need for heterosexual men to become more active in asserting their heterosexuality (Herek, 1986, 1990). Additionally, as the male sex role has become superficially more flexible during this period, the need to assert the heterosexual component of masculinity has increased (Herek, 1986). The mocking of gay men or the denial of being gay are ways that a man can assert their heterosexuality and demonstrate that they are conforming to their gender role (Harry, 1990; Herek, 2002, 2000b, 1986). By expressing anti-gay prejudice or attacking gay men, heterosexual men can win approval from their

peers, friends and family and boost their self-esteem (Harry, 1990; Herek, 1990; Mason, 1993; Tomsen, 1996; Tomsen & George, 1997). It is also a mechanism in expressing values that they find personally important (Herek, 1990).

The anti-gay attitudes and behaviours of heterosexual men are believed to be maintained through societal expectations that pressure them to behave in certain ways (Herek, 1986). This societal pressure to conform is internalised, so that these men experience anxiety when they struggle to live up to these standards (Herek, 1986). The basis of this anxiety is a fear of losing their self-identity as a heterosexual man (Herek, 1986). By behaving or acting in an anti-gay manner these men can relieve this anxiety (Herek, 1990). Some have suggested that there are age related trends in anti-gay violence, due to males on the verge of adulthood being less secure in their gender role than adult men (Harry, 1990). Many violent attacks on gay men are random attacks on men who are assumed gay, often due to their presence in a particular geographic location (Bull et al., 1991; Harry, 1990; Mason, 1993; Tomsen, 1996). Offenders also target men who they perceive to be acting in an effeminate manner or look effeminate (Harry, 1990). These attacks often consist of or are accompanied by the use of words that convey hatred towards gay men, such as “faggot” (Garnets, Herek, & Levy, 1990). Violence against gay men involves physical assaults and murders, as well as harassment, abuse (Mason, 1993), threats (Garnets et al., 1990) and property damage (Harry, 1990).

Both threats to male masculinity and a hatred of homosexuality are believed to motivate violent attacks on gay men (Mouzos & Thompson, 2000; Tomsen, 1996, 2006; van der Meer, 2003). A qualitative study (van der Meer, 2003) of young men in the Netherlands who bashed men they believed to be gay,

found that these men believed that they were acting in the best interests of society. These offenders expressed a range of remorse, from those that did not care for their victims at all, to those that experienced regret and remorse for their actions. These offenders also reported that they gained prestige within their peer group through participating in these acts of violence. There was a belief that through bashing gay men they were demonstrating that they were not gay and that they were not weak. They also expressed the opinion that gay men were soft-targets, as they would not fight back. These offenders argued that all gay men were effeminate, cowards and weaklings and could be recognised by their physical appearance and movements. Additionally, these offenders insisted that the only "good" gay men were those that were not recognisable as gay. All of the interviewees argued that another man finding them sexually desirable not only made them uncomfortable, but also justified them becoming violent should they be aware of this desire through either a look or a gesture.

The results of Australian studies (Mouzos & Thompson, 2000; Tomsen, 2006, 1996) of gay-hate homicides in New South Wales, demonstrate that these homicides tend to follow distinct patterns. Most of these murders involved young men attacking middle-aged or older men (Mouzos & Thompson, 2000; Tomsen, 1996). Further, the records of the Coroner's Court for this period reveal that gangs of young men were suspected to be responsible for unsolved gay-hate murders (Tomsen, 1996). Most victims of murder are killed by someone that they know, but a greater number of victims of gay-hate crimes were killed by strangers (Mouzos & Thompson, 2000). Many of these murders occurred after some form of socialising (Mouzos & Thompson, 2000; Tomsen, 1996). Some of the male perpetrators of this violence against gay men engaged in sexual acts

with other men, before committing acts of violence (Tomsen, 1996, 2006). Gay-hate homicides were more likely to involve more than one offender than other types of murder (Mouzos & Thompson, 2000). Most of these victims were beaten to death with either foot or fist, but others were killed with a blunt object or a knife (Mouzos & Thompson, 2000; Tomsen, 1996). These murders tended to be extremely brutal, characterised by an unnecessary high level of violence, such as a large number of stab wounds (Mouzos & Thompson, 2000; Tomsen, 1996).

1.2.1.11. Anti-Gay Attitudes and Violence

There have been concerns that common negative beliefs about gay men have affected the outcome of the trails of men accused of killing gay men (Berrill & Herek, 1990; Tomsen, 1996; Tomsen & George, 1997). It became common, during the 1990's for the accused to claim that the victim either made a pass at them or assaulted them in some way (Tomsen, 1996). The accused in these cases used the defence of either self-defence against sexual assault or provocation, due to an unwanted sexual advance from the victim. Those using these defences tended to receive lighter sentences and less serious charges than would be expected or were acquitted (Tomsen, 1996; Tomsen & George, 1997). In Anglo-American legal tradition there has been a past acceptance of certain slights provoking violence in men and in cases where either acquittal or a finding of manslaughter occurred this defence of provocation appears to have been accepted (Tomsen, 1996; Tomsen & George, 1997). In this way, revulsion, fear and hostility have been seen as normative responses to the sexual behaviour of gay men (Berrill & Herek, 1990; Tomsen & George, 1997). During some murder trials, the defence presented the victim as expressing unwanted sexual interest in

a young man, implying that the victim was a paedophile (Tomsen, 1996; Tomsen & George, 1997). On other occasions, the defence have argued that the victim was a paedophile or that the victim was in an area where a paedophile was known to be (Tomsen, 1996; Tomsen & George, 1997).

A more recent study (Plumm, Terrance, Henderson, & Ellingson, 2010) provides evidence that peoples' attitudes affect their tendency to blame the victim of a gay hate crime. These researchers used a scenario of a gay man being beaten up in a bar after he asks to buy his attacker a drink. The location of the scenario varied between groups of participants, with the assault occurring in a gay bar for some groups and in a local bar for other groups. In all conditions, all of the participants indicated that they thought that the attacker was guilty of an assault. Those participants in the gay bar condition, however, were more likely to blame the attacker than those participants in the local bar condition, while those in the latter condition were more likely to blame the victim than those in the former condition. Participants were also more likely to blame the victim, regardless of setting, if the victim placed his arm around the attacker and asked him to dance rather than just ask to buy him a drink. These researchers concluded that the victim is more likely to be blamed when others perceive their actions to be either unexpected, given the situation, or unacceptable.

1.2.1.12. The Prevalence of Anti-Gay Violence and Harassment

Additionally, research provides evidence that these prejudicial attitudes in the general community resulted in the frequent occurrence of harassment and violence towards gay men (D'Augelli & Grossman, 2001; Herek, 2009; Herek, Gillis, & Cogan, 1999; Huebner, Rebohook, & Kegeles, 2004; Otis, 2007; Waldner & Berg, 2008). For example, the results of a recent population survey

(Herek, 2009) indicated how common harassment and violence against gay men was in the US. This study found that 39% of gay men were victims of violence, property crime or attempted crime, 21.1% had objects thrown at them, 35.4% were threatened with violence and 63% were verbally abused.

1.2.1.13. Characteristics of Anti-Gay Violence and Harassment

Herek, Cogan, and Gillis (2002) found that significantly greater proportion gay, lesbian and bisexual hate-crime victims were victimised by multiple-perpetrators than victims of non-hate crimes. These researchers also found that hate-crimes against the person were committed significantly more often by strangers than non-hate crimes, but hate crimes involving property were more often committed by people known to the victim than non-hate property crimes. Nearly all the men in this study were victimised by other men, with only 2% mentioning the involvement of a woman. Their results also indicated that these hate crimes could occur in their residence, work place or place of study, such as a university campus. These interviews revealed that many incidents of victimisation occurred in the proximity of known gay venues or other public spaces, such as parks. Stotzer (2010) used the regression analysis of demographic variables, controlling for differences in the number of residents, to predict the incidence of sexual orientation hate crimes in different areas of Los Angeles. The results of this analysis indicated that sexual orientation hate crimes were more likely to occur in areas that had a higher entertainment outlet density, lower population density and lower median income. This researcher concluded that these results indicated that many hate crimes against sexual minorities were crimes of opportunity that occurred in public spaces.

In the US, gay men are more likely to be victims of hate related violence than lesbians or bisexuals (D'Augelli & Grossman, 2001; Herek, 2009; Herek et al., 1999). Herek et al. (1999) found that among gay men, lesbians and bisexuals, men were more likely than women to be victims of hate crimes, with one in four men and one in five women being victims of a hate crime at least once in the past five years. More recently gay men were found to be significantly more likely to be victims of hate-crimes against the person or property and they were significantly more likely to be harassed due to their sexual orientation than either lesbians or bisexuals (Herek, 2009). D'Augelli and Grossman (2001) found that sexual minority men were significantly more likely than women to be threatened with violence or a weapon and to be punched, kicked or beaten. These researchers also found that men were almost three times more likely to experience physical assault than women were, when gender differences in the overall experience of victimisation was considered.

Another factor associated with victimisation among gay men, in the US, is their openness about their homosexuality (D'Augelli & Grossman, 2001; Herek, 2009; Herek et al., 2002; Herek et al., 1999; Waldner & Berg, 2008). Studies have found that men who were open about their sexual attraction to same-sex others, were significantly more likely to be harassed, discriminated against (Herek, 2009) or be victims of a hate crime (Herek et al., 1999). Waldner and Berg (2008) found that how open a gay man was about his sexuality and his amount of contact with gay organisations, venues and events were predictors of being a victim of both anti-gay property crimes and physical attacks. They found that those open about their sexuality were 3.4 times more likely to be physically victimised and 2.8 times more likely to have property damaged, due to sexual

orientation than those more closeted. Similarly, those with more contact with gay organisations, venues and events were 1.1 times more likely to be physically victimised and 1.2 times more likely to experience property damage than those with less contact. Similarly, D'Augelli and Grossman (2001) found that those participants who had spent a greater percentage of their lives aware of their sexuality, identifying as gay, lesbian, or bisexual and disclosing their sexuality to others experienced more victimisation, than those who had spent a smaller percentage of their time doing these things.

1.2.1.14. The Impact of Gay Victimisation

Some US gay men do not report being a victim of a hate crime due to a fear of being outed (Herek et al., 2002; Herek et al., 1999). Herek et al. (1999) found in their study that gay men, lesbians and bisexuals who were victims of hate-crimes were less likely to report these crimes to the police than those who had been victims of non-hate crimes. In a follow up study, Herek et al. (2002) found that interviewees who said that they did not report serious crimes to police, the victims of hate-crimes were significantly less likely to report these crimes to police than the victims of non-hate crimes. The participants in this study who reported a hate-crime were significantly more likely to believe that doing so revealed their sexual orientation to police than victims of non-hate crimes. They also found that of those who believed that police were aware of their sexual orientation, those reporting a hate-crime were more likely to believe that this affected the way case was investigated, than victims of non-hate crimes. These researchers concluded that victims of hate-crimes appear to only report incidents if they believe that such a report would lead to a successful outcome.

There is evidence of an association between the victimisation of gay men and fear of this victimisation (Otis, 2007) and victimisation and further victimisation (Friedman, Marshal, Stall, Cheong, & Wright, 2008). Otis (2007) found that there was an association between the experience of victimisation in the previous two years, among US gay, lesbian, bisexual and transgender adults, and a fear of future victimisation. This study also found that there was an association between problems of incivility in an individual's neighbourhood and their fear of victimisation. Regression analysis indicated that both neighbourhood incivility and past victimisation predicted a fear of victimisation. Additionally, regression analysis revealed that being a victim of a hate-crime against property predicted a fear of being a victim of such a crime. Similarly, being a victim of a hate-crime against the person predicted fearing this type of victimisation. Neighbourhood incivility was found to be a predictor of fearing physical and property victimisation. The variables of property victimisation and neighbourhood incivility predicted perceived risk of property victimisation. Similarly, both personal victimisation and neighbourhood incivility predicted perceived risk of physical victimisation. Friedman et al. (2008) found that 74% of their sample of US gay men reported experiencing harassment due to their sexual orientation before the age of 17 years. This early gay related harassment was found to be positively associated with gay related harassment as an adult, but not depression or suicide attempts.

An Australian survey study of participants involved in gay and lesbian events (Tomsen & Markwell, 2009), such as the Sydney Gay and Lesbian Mardi Gras, found that 89% of the incidents of harassment or violence witnessed by these participants at these events, involved "straight" perpetrators and gay or

lesbian victims. About a quarter witnessed at least one or two incidents, 15% witnessed two or three incidents and 9% witnessed six or more incidents. Almost a third of participants reported that they had been a victim of either harassment or violence at such an event, with almost two thirds of these participants being a victim on one or two occasions. The most common reason that participants gave for being victims were homophobia or ignorance (21.9%) and visibility (dress and behaviour; 33.3%).

The results of this study (Tomsen & Markwell, 2009) indicate that women (34%) reported witnessing more incidents of harassment, verbal abuse and threats than men (31%), whereas men (11%) reported witnessing a greater number of incidents involving physical violence than women (8%). Men reported a higher incidence of threats and experience of violence, whereas women reported a higher incidence of sexual harassment. Out of the 151 incidents that participants detailed to these researchers only four mentioned the involvement of police and the number of hostile incidents reported by the participants are much larger than the number reported publicly by community groups, the media or the police. The participants in this study reported feeling less safe immediately after an event, than they did in the time before and during an event. There were some reports of harassment or abuse before or during events, but the incidence of such events increased after events had ended.

Malicious behaviours towards gay men undermine the mental health of this population (D'Augelli & Grossman, 2001; Herek et al., 1999; Josephson & Whiffen, 2007; Rivers, 2004). Gay and lesbian victims of recent hate crimes experience more symptoms of depression, trauma, anger and anxiety than gay and lesbian victims of non-hate crimes against the person do or those who were

not victims of crime do (Herek et al., 1999). D'Augelli and Grossman found that when compared to those who had experienced no victimisation or only verbal abuse, victims of physical abuse had significantly lower self-esteem and higher suicide ideation. In addition, the latter reported significantly less positive changes in their mental health over the previous five years than the former two groups and were more likely to have attempted suicide. Those who had experienced any form of victimisation were significantly lonelier than those that had never been victimised. Among Canadian gay men, there was a positive correlation between being bullied during childhood and depressive symptoms in adulthood (Josephson & Whiffen, 2007). Similarly, in Britain lesbians and gay and bisexual men the childhood experience of being bullied due to either perceived or actual sexual orientation was more likely to result in an individual experiencing depressive symptoms in adulthood. This study also found an association between this type of bullying and individuals being less accepting of their own sexuality as an adult, if the individual had symptoms of trauma due to this bullying (Rivers, 2004).

1.2.1.15. Coping with Anti-Gay Violence and Harassment.

Lucies and Yick's (2007) qualitative study of US gay men (found that these men were subjected to negative behaviour from childhood and through adolescence, due to others perceiving them as either effeminate or gay. These gay men reported that they felt outcasts, because of this abuse, due to their perception that they were not meeting the expected cultural standards of masculinity or heterosexuality. This perception led to them experiencing low self-esteem, loneliness, shame and negative affect. The anti-gay abuse that occurred when these men were growing up was experienced in their school,

neighbourhood and family home. The perpetrators of this abuse varied from family members and peers to complete strangers. This abuse could take the form of physical violence and verbal and psychological abuse. Some of these men attempted to overcome their negative feelings to being gay by engaging in heterosexual sex or marrying a woman, confessing the "sin" of homosexuality to a priest and joining the military or a religious order. They did this in an attempt either to become straight or to compensate for being gay. Other forms of coping with this abuse involved some form of self-punishment. Some examples of this behaviour were substance abuse, suicidal behaviour, self-mutilation, sexually promiscuous behaviour, unsafe sex, prostitution and remaining in an abusive relationship.

An interview-based study (Willis, 2008) investigated the response of seven gay men in the US to being victims of a violent hate-crime. In each incident, described by the participants, the assailants used phrases such as "faggot" and "homo". All the participants interpreted the use of these phrases as the perpetrators expressing their hatred of gay men. Descriptions of these attacks indicated that they were brutal assaults, due to the amount and type of violence used. All of these men were attacked in locations that they previously considered relatively safe, such as private homes or parking lots, leading to them to consider these environments less safe and predictable than what they did prior to the attack. The men in this study took varying amounts of time to heal both physically and mentally from their attacks, with the former tending to take shorter duration than the latter. Recovery from physical injuries varied from one to two weeks, whereas recovery from mental injuries took from seven months to

11 years. They all reported increased vigilance in both public and private spaces after their assault.

These men also commented on the physical and non-physical forms of self-defence that they used during these attacks, such as fighting, speaking to or glaring at their attackers (Willis, 2008). Such acts were considered by the participants to be not only important in protecting themselves physically, but also important in preventing themselves from absorbing the dehumanising hatred of their attackers. These participants also described how they attempted to come to terms with their experiences by actively finding a reason for their experience and constructing a positive meaning, such as it strengthening them in some way. These participants also mentioned that they received inadequate support from family, friends and work colleagues, as well as the professionals that they dealt with, such as paramedics and police. Although all expressed the belief that intimacy is important, they also expressed an inability to enter and maintain intimate relationships after being a victim of a hate-crime. Additionally, all these men experienced less interest in social interaction and social activities and felt more alone after the attack than they did before the attack.

An Australian survey study of participants involved in gay and lesbian events (Tomsen & Markwell, 2009) found many participants actively engaged in behaviours that they believed reduced their risk of unwanted attention, especially those aged between 18 and 35 years. Nearly 40% of participants mentioned that they altered their physical appearance when travelling to and from an event, by changing clothes or makeup or they began “acting straight”. Gay men in particular tended to tone down their appearance for the journey to and from the event, as they believed that this would reduce the likelihood of being assaulted.

Additionally, they would intentionally not act in an affectionate manner towards their same-sex friends or partners. Other common strategies involved staying in a group and using private rather than public transport.

Mason (2001) argues that anti-gay violence is linked to the visibility of homosexuality, describing how her research indicates that to avoid harassment due to sexual orientation individuals conceal any observable indication of homosexuality. Some people object to the public display of homosexuality rather than its existence (Mason, 2001). Incidents of anti-gay violence not only affect the victim, but also affects all gay men, as these incidents suggest that homosexuality is not accepted (Mason, 1993) and any man identified as gay risks being assaulted (Mason, 2001). By being closeted or selectively being open about their sexuality helps protect gay men from being discriminated against or harassed due to their sexuality (Mason, 2001). To achieve this, a gay man has to consider what is considered acceptable behaviour and appearance for a man of their ethnicity and social economic status (Mason, 2001). These men also avoid behaviours such as publicly holding hands or kissing a same sex partner (Mason, 2001). By altering or maintaining a certain appearance to avoid being seen as gay, these men are being influenced by attacks on men who are identified as gay (Mason, 2001). How safe gay men feel and how this affects their openness about their sexuality depends on the social context that they are in (Mason, 2001). In this way, gay men are exercising control when they make decisions about how open they are about their sexuality, so that they are not being merely reactive to homophobia (Mason, 2001).

1.2.1.16. Anti-Gay Prejudice Summary

In summary, research indicates that gay men are potential targets of harassment, violence, threats and property damage, due to their sexual orientation (e.g., Herek, 2009). Gay men are also subjected to discrimination and being exposed to prejudicial views or opinions about gay men, in everyday life (Swim et al., 2007). These attacks create fear of further attacks among the gay victims (Otis, 2007) and adversely affect the mental health of gay men (D'Augelli & Grossman, 2001). Theorists argue that gay men are targeted due to their perceived violation of accepted gender roles and the negative attitudes that exist towards same-sex sexual interaction (e.g., Herek, 1986). These negative attitudes are held by a large proportion of the adult population and especially by men (Kelley, 2001). Both men and women, but especially the former, have more negative attitudes towards gay man than they do towards lesbians (Herek, 2002). These negative attitudes are cultural in origin and are maintained and developed through social intuitions, such as schools and families (Herek, 1990). To overcome this prejudice gay men use a number of strategies, such as not showing affection to their same-sex partner in public (Tomsen & Markwell, 2009). Despite these efforts to protect themselves from the negative attitudes towards there sexuality, these attitudes can still influence how gay men see themselves.

1.2.1.17. Stigma, Gay Identity and Gender Role Confusion

The stigma that gay men face from certain members of the community affect how these men view their sexual orientation and how positive they feel about themselves (Frable, Wortman, & Joseph, 1997; Frost, Parsons & Nanin, 2007). Frable et al. found in the US that stigma from family, stigma towards other gay men and stigma in general, all predicted lower positive self-perception,

as did being openly gay. Being openly gay and being involved in social networks of gay men predicted a more positive gay identity, but stigma from one's family was associated with a less positive gay identity. Finally, the more positive the gay identity possessed by a gay man, the more positive their self-perception. Frost et al., found that there was a positive correlation between feeling stigmatised due to sexual orientation and depression, as well as a positive correlation between the concealment of sexuality and depression. Additionally, this study found that concealing sexuality partially mediated the relationship between sexual orientation stigma and depression.

Australian research suggests that different stages of gay identity formation among men sexually attracted to other men, affect how much distress they experience due to their sexual identity (Halpin & Allen, 2004). These researchers found that men in the early stages of gay identity formation, when the individual has limited awareness of their actual sexual identity and tend to be "closeted", did not experience much psychological distress. There was, however, a strong association between higher levels of psychological distress and identity formation stages associated with coming out. The authors of this study argue that this increased level of distress may be due to increased social judgement and stigma during this period as well as less contact with gay peers and possibly a lack of confidence in identifying in this way. Their results indicate that as men in the later stages of gay identity formation become comfortable with identifying as gay, they experience less distress than when they were initially coming out.

The more gender role conflict US gay men experience the more depression they experience (Blashil & Val, 2010; Simonsen, Blazina, & Watkins, 2000; Szymanski & Carr, 2008) and the more negative they feel about being gay

(Sanchez, Westfield, Liu, & Vilain, 2010). Simonsen et al. (2000) found that the more difficulty gay men had expressing emotion or affection the more depression they experienced. These researchers also found that the more importance that gay men gave success, power, competition and work, the more depressed they were (Simonsen et al., 2000). Szymanski and Carr found that higher levels of gender role conflict led to lower levels of self-esteem, which in turn led to higher levels of psychological distress in gay men. In their study, Blashil and Val found that gender role confusion mediated the relationship between social sensitivity and depression in gay men. They also found two components of gender role confusion, restricting emotional expression and putting work first, independently mediated this relationship. Finally, Sanchez et al. found that higher scores for the importance of self and partner appearing masculine and actual and ideal masculinity were all positively associated with more negative feelings about being gay. These researchers also found that the more concern with demonstrating masculine traits, such as being successful, putting work first, and restricting emotion and affection, the more negative feelings gay men had about being gay.

1.2.1.18. Internalised Homophobia

Internalised homophobia is widely used to describe a particular reaction that some gay men have to the negative attitudes and behaviours that they are exposed to, due to their sexuality (Balsam & Mohr, 2007; Meyer, 1995; Ratti, Bakeman, & Peterson, 2000; Shidlo, 1994; Williamson, 2000). Internalised homophobia has also been referred to as *internalised heterosexism* (Herek, Gills, & Cogan, 2009; Szymanski, et al., 2008a) and *self-stigma* (Herek et al., 2009). Some argue that the term internalised heterosexism better conveys the influence

of society and culture on how gay men perceive themselves than internalised homophobia (Szymanski, et al., 2008a). Internalised homophobia can affect any one that engages in same-sex behaviours or attraction regardless of whether they identify themselves as gay (Igartua et al., 2003). Shidlo (1994) cites two US surveys that show the prevalence of internalised homophobia among gay men is around 30%.

There has been a lot of focus on internalised homophobia in psychological research (Shidlo, 1994; Williamson, 2000). Most of the research into internalised homophobia has been aimed at designing interventions for mental disorders or trying to explain the origins of these disorders among gay men (Williamson, 2000). Due to this research, an increasing amount of evidence links an individual's level of internalised homophobia with the likelihood of developing psychopathology and the reduction of internalised homophobia with successful intervention outcomes (Williamson, 2000).

1.2.1.19. Internalised Homophobia and Associated Variables

Recent studies have linked internalised homophobia to a sense of social alienation (Preston, D'Augelli, Kassab, & Starks, 2007; Herek et al., 2009; Ratti et al., 2000; Ross & Rosser, 1996). Among US gay men, lesbians and bisexuals, higher levels of internalised homophobia was predicted by more negative feelings about gay, lesbian or bisexual communities (Herek et al., 2009). This study also found that the more out these participants were the less internalised homophobia they experienced, especially if non-family members were aware of their sexuality (Herek et al., 2009). Ross and Rosser performed a factor analysis of their internalised homophobia scale, using a sample of US men who have sex with men. Items associated with concern about being publicly identified as gay

and a lack of comfort socialising with gay men were associated with being less open about their gay or bisexual lifestyle. These items were also associated with not joining gay or bisexual groups, lower relationship satisfaction and more time spent around other gay men. Additionally, these items were related to having a stronger sexual attraction for women rather than for men. In the US, the more internalised homophobia experienced the less accepting an individual's community and family were of gay men and AIDS-HIV sufferers (Preston et al., 2007). Finally, Ratti et al. Found that among a Canadian men who had sex with men higher levels of internalised homophobia was associated with less acculturation to the gay or general communities and greater amounts of high-risk sexual behaviour.

A study by Cox, Dewaele, van Houtte, and Vincke (2011) provides further evidence that an individual's level of internalised homophobia is associated with how much their social network accepts their sexuality. Their results indicate that among 14 – 30 year olds in the US who identified as gay, lesbian or bisexual, those who felt that those around them accepted their sexuality perceived themselves as growing more because of the coming out process. Those who found it difficult to disclose their sexuality to others or felt that those around them did not accept their sexuality had higher levels of internalised homophobia. The participants who disclosed their sexuality to a larger number of people and wider range of people (e.g., family, friends, and teachers) had lower levels of internalised homophobia. Lower levels of internalised homophobia were found in participants who felt stronger ties to the gay, lesbian or bisexual communities. Finally, the participants who perceived

more personal growth through coming out had lower levels of internalised homophobia.

There is an association between internalised homophobia and low self-esteem (Allen & Olsen, 1999; Preston et al., 2007; Rowen & Malcolm, 2002; Szymanski & Carr, 2008; Szymanski, Kashubeck-West, & Meyer, 2008b). Rowen and Malcolm found that among Australian men who had sex with men, higher levels of internalised homophobia were associated with lower levels of self-esteem and poorer self-concept regarding emotional stability and physical appearance. Additionally, higher levels of internalised homophobia were associated with less well-developed gay identity and a greater amount of sex guilt. Finally, they found that levels of perceived anti-gay stigma in an individual's environment predicted their level of internalised homophobia. Greater amounts of internalised homophobia was associated with less sexual sensation seeking and lower self-esteem among US rural men who had sex with men (Preston et al., 2007). Allen and Olsen, 1999) found an association, in the US, between higher levels of internalised homophobia and low self-esteem and higher levels of internalised homophobia and higher levels of shame. Finally, higher levels of internalised homophobia predicted lower levels of self-esteem among US gay men (Szymanski & Carr, 2008). In their review of the literature Szymanski et al., (2008b) concluded that most studies found that higher levels of internalised homophobia was associated with lower self-esteem, less disclosure of sexuality, gender role conflict and social support and earlier stages of gay identity formation.

Allen (2002) found among US gay men that personality types that tended to deny psychological problems, such as narcissistic, were associated with lower

levels of internalised homophobia. In contrast, those that tended to exaggerate difficulties, such as depressive, were associated with high levels of internalised homophobia. Additionally they found that personality types that tended to cope by turning against themselves were high in internalised homophobia whereas those that tended to turn against others were low for internalised homophobia. Turning against the self tends to be characterised by self-degradation, self-blame and self-hatred whereas those who turn against others do not accept blame for their problems and are dismissive of others who criticise them. Most of the personality types that predict high levels of internalised homophobia tended to be characterised by poor self-concept and some of these were characterised by the need for social approval.

There is an association between internalised homophobia and the development of psychopathology (Igartua et al., 2003; Frost & Meyer, 2009; Gold, Marx, & Lexington, 2007; Meyer, 1995; Newcomb & Mustanski, 2010; Preston et al., 2007; Szymanski et al., 2008b; Wagner, Brondolo, & Rabkin, 1996), including depression. Meyer found that US gay men with higher levels of internalised homophobia tended to experience more demoralisation, guilt, suicide, AIDS related traumatic stress and sexual problems. This study also found that there was an interaction effect between internalised homophobia and the experience of prejudice, in predicting either demoralisation or guilt, so that the presence of higher levels of internalised homophobia strengthened the relationship between prejudice and either demoralisation and guilt leading to poorer outcomes. Additionally, US gay sexual assault survivors with higher levels of internalised homophobia in tended to experience higher levels of depressive symptoms (Gold et al., 2007). Szymanski et al. concluded from their

review of the literature that most studies have found a positive association between internalised homophobia and psychological distress.

1.2.1.20. Internalised Homophobia and Depression

Frost and Meyer (2009) found that US gay men, bisexuals and lesbians with higher levels of internalised homophobia had higher levels of depressive symptoms. Additionally, this study found that depression mediated the relationship between internalised homophobia and relationship quality, so that individuals with higher levels of homophobia tended to have poorer quality relationships due to their tendency to experience more depressive symptoms. Among US gay men, internalised homophobia was associated with the number of depressive symptoms at baseline and at follow up two years later (Wagner et al., 1996). In their meta-analytic study, Newcomb and Mustanski (2010) found that there was a small to moderate correlation between levels of internalized homophobia and the number of depressive symptoms.

Igartua et al. (2003) found that the more internalised homophobia Canadian gay men, lesbians and bisexuals experienced the more depression, anxiety and suicidal impulses they experienced. The component of internalised homophobia that had the strongest association with these forms of psychological distress was the individual's attitudes towards their own sexuality. Multiple regression analysis revealed that internalised homophobia predicted both anxiety and depression, but was not a significant predictor of suicidal impulse. These researchers concluded that this finding indicated that internalised homophobia may indirectly affect suicidal impulses through its direct relationship with depression that in turn is directly related to suicidal impulses.

In contrast, two US studies have failed to find an association between internalised homophobia and depression (Lewis, Derlega, Griffen, & Krowinski, 2003; Span & Derby, 2009). Both of these studies used samples of gay men, lesbians and bisexuals that had low levels of internalised homophobia and this may have led to a restricted range of variance in this variable (Lewis et al., 2003; Span & Derby, 2009). In their study, Lewis et al. found an association between higher levels of stress associated with being gay or lesbian and more depressive symptoms. They also found that the more conscious a participant was of the stigma related to their sexuality the more depressive symptoms they reported.

There is evidence that the relationship between internalised homophobia and depression is complex and is mediated by other variables (Blashill & Wal, 2010; Herek et al., 2009; Riggle, Rostosky, & Horne, 2010; Szymanski & Carr, 2008). Among US gay men, lesbians and bisexuals, higher levels of internalised homophobia was associated with lower levels of self-esteem, which in turn was associated with lower levels of positive affect and higher levels of depression (Herek et al., 2009). Similarly, Szymanski and Carr found that self-esteem mediated the relationship between internalised homophobia and psychological distress . Riggle et al. found that among gay men lesbians and bisexuals in the US, relationship status affected levels of both internalised homophobia and depression. Those who were single had higher levels of internalised homophobia and depression than those in committed or legally recognised relationships. The participants who were dating had higher levels of internalised homophobia than those in committed and legally recognised relationships and more depressive symptoms than those in a legally recognised relationship. Finally, those participants in a committed relationship had higher levels of internalised

homophobia and depressive symptoms than those in legally recognised relationships.

1.2.1.21. Internalised Homophobia Summary

In summary, internalised homophobia has been linked to poorer mental health, including increased levels of depression (Igartua et al., 2003). Individuals with higher levels of internalised homophobia experience lower self-esteem and more shame (Rowen & Malcolm, 2002), less comfort with socialising with other gay men (Ross & Rosser, 1996), and feel stigmatised in either their family or community (Preston et al., 2007). Additionally, a lack of acculturation to either the gay or general communities has been found to be associated with internalised homophobia (Ratti et al., 2000). There is also evidence of an association between internalised homophobia and a tendency to exaggerate or internalise problems (Allen, 2002). The research suggests that link between internalised homophobia and depression may be the result of an individual struggling to cope with or manage society's negative beliefs towards homosexuality.

1.2.2. Protective Factors

Although it is evident that there is a direct relationship between depression and internalised homophobia (Gold et al., 2007; Igartua et al., 2003; Wagner et al., 1996), the prevalence of major depression is usually given as being lower among gay men than the prevalence of internalised homophobia (Wang et al., 2007). Cochran et al. (2003) found a 12-month prevalence rate for major depression of 31% among gay and bisexual men. These researchers, however, did not differentiate between these two groups and there is evidence that these groups differ on measures of mental health (Cochran & Mays, 2009; Jorm et al., 2002). Another study found a 21.5% of gay men, 15.7% of bi-sexual

men and 30.7% of homosexually experienced heterosexual men had major depression in a 12-month period (Cochran & Mays, 2009). Most studies have found a 10 - 20% prevalence rate of major depression among gay men or men who have sex with men (Cochran & Mays, 2000a; Cochran & Mays, 2000b; Gilman et al., 2001; Wang et al., 2007), which is lower than the 30% prevalence rate of internalised homophobia (Shidlo, 1994). This suggests that there are protective factors involved that prevent internalised homophobia from developing into depression among gay men.

1.2.2.1. The Theory of Human Relatedness

A theory that may explain how certain types of protective factors may reduce the influence of internalised homophobia on the development of depressive symptoms is the theory of human relatedness (Hagerty, Lynch-Sauer, Patusky, & Bouwsema, 1993). Central to this theory is the concept of *relatedness*. This term refers to how involved and comfortable a man is when interacting with other people or objects that he encounters in his environment (Hagerty et al., 1993). According to this theory, a reduction in a man's relatedness can undermine his biological, psychological and social functioning, resulting in further deterioration in his level of relatedness (Hagerty et al., 1993).

According to this theory, there are four states of relatedness: (a) connectedness, (b) disconnectedness, (c) parallelism and (d) enmeshment (Hagerty et al., 1993). The exact state of relatedness that a man experiences can vary from one situation to the next and the duration, intensity and frequency that he experiences each of these states over time, will also vary (Hagerty et al., 1993).

A man experiences connectedness when he is actively involved with the people, environments and objects that he encounters and this connectedness can enhance his wellbeing and comfort and reduce any anxiety (Hagerty et al., 1993). In contrast, disconnectedness occurs when a man lacks this involvement, resulting in him experiencing less wellbeing and more discomfort and anxiety (Hagerty et al., 1993). Parallelism occurs when a lack of involvement in his surroundings and his interaction with objects and people does not undermine a man's level of comfort or wellbeing (Hagerty et al., 1993). Finally, enmeshment results from a man's involvement in his environment and the people and objects around him not enhancing his level of comfort or reducing his anxiety (Hagerty et al., 1993).

1.2.2.2. Sense of Belonging

A component of relatedness that is a known protective factor against the development of depression from a variety of risk factors is *sense of belonging* (Bailey & McLaren, 2005; Cheonarom, Williams & Hagerty, 2005; Hagerty, Williams, Coyne, & Early, 1996; McLaren & Challis, 2009; McLaren, Gomez, Bailey, & Van Der Horst, 2007; McLaren, Jude, Hopes, & Sherritt, 2001). A man has a sense of belonging when he perceives that his personal characteristics facilitate his social interactions and his encounters with the environment, resulting in him feeling valued, needed and accepted (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992; Hagerty et al., 1993). According to the theory of human relatedness, sense of belonging creates and enhances relatedness states (Hagerty et al., 1993). In this way, how well connected a man feels with various relationships depends on his level of sense of belonging, with higher levels resulting in him feeling more connected (Hagerty et al., 1993). Studies

have found that sense of belonging is related to depression in community samples of adults (McLaren et al., 2001), older adults (Bailey & McLaren, 2005; McLaren, Gomez et al., 2007), university students (Hagerty et al., 1996), those with major depression (Cheonarom et al., 2005), male farmers (McLaren & Challis, 2009) and lesbians (McLaren, 2009).

1.2.2.3. Sense of Belonging among Gay Men

Commentators have argued that gay men feel better about themselves when around similar others (Garnets et al., 1990; Johnson & Johnson, 2001) and there is some support from research for this argument (Frable, Platt, & Hoey, 1998). As heterosexuals raise most gay and bisexual men, Johnson and Johnson (2001) argued that these men needed to develop a sense of belonging through involvement in support groups, so they can develop a positive identity. Similarly, Garnets et al. (1990) argued that gay men who are victimised after coming out, are better equipped to cope with victimisation, due to having developed a supportive social network, as well as having gay community resources and non-heterosexist interpretations of this victimisation. US university students who were members of concealable and stigmatised minorities, such as gay men, were found by Frable et al. to experience more depression and lower self-esteem than students who were members of a conspicuous and stigmatised minority group, such as African-Americans. They also found that when members of these concealable and stigmatised minorities were around similar others, both their self-esteem and mood improved.

Only a small amount of research has investigated sense of belonging among gay men or adolescents (Hagerty, Williams & De, 2002; McCallum & McLaren, 2011; Murdoch & Bolch, 2005). Murdoch and Bolch (2005) explored

sense of belonging among gay adolescents, but only in the context of education. These researchers found that psychological sense of school belonging was negatively associated with anti-gay attitudes and behaviours at a school and positively associated with support from teachers, parents and a friend. McCallum and McLaren found among Australian gay, lesbian and bisexual teens that increased levels of both sense of belonging to the general community and sense of belonging to a support group for sexual minority adolescents independently reduced depression. Additionally, they found that sense of belonging to the general community mediated the relationship between sense of belonging to the support group and depression. In this way, sense of belonging to the support group facilitated sense of belonging to the general community, so that there was a beneficial impact on the mood of these participants. Hagerty et al. (2002) found in their study that the presence of homosexuality in a person's family during childhood reduced that individual's sense of belonging in adulthood. This was a retrospective study, however, and the homosexuality could relate to the participant or the participant's immediate family. Those participants that indicated that they experienced homosexuality in childhood only made up 3% of the total sample.

Currently only two published studies that have investigated sense of belonging among gay men (McLaren, Jude, & McLachlan, 2007, 2008). McLaren, Jude et al. found that gay men had lower levels of sense of belonging to the general community and higher levels of depressive symptoms than heterosexual men. Further, the results indicated that sense of belonging mediated the relationship between sexual orientation and depression, so that being gay was associated with lower levels of sense of belonging to the general community,

which in turn was associated with higher levels of depression. As the results of this study indicated that gay men did not have as strong sense of belonging to the general community as heterosexual men did, McLaren et al. (2008) explored the possibility that a sense of belonging to the gay community may compensate for a lack of sense of belonging to the general community. They found that a strong sense of belonging to the gay community and sense of belonging to the general community were both independently and directly related to lower levels of depressive symptoms among gay men. Additionally, they found that sense of belonging to the gay community partially mediated the relationship between sense of belonging to the general community and depression and that the sense of belonging to the general community partially mediated the relationship between sense of belonging to the gay community and depression.

1.2.2.4. Sense of Belonging and Different Spheres of Gay Community

In their study, McLaren et al. (2008) defined gay community as viewing gay men collectively. Woolwine (2000), in his qualitative study, identified this type of gay community as being one of three forms of gay community and the one that gay men identified with the least. The first of these different types of gay community was the imagined community that is a perception of belonging to a wider group of individuals, “gay people”. Although this imagined community existed among these gay men, not all the participants saw this imagined community as unified. Rather there was a perception of this imagined community being divided into various sub-groups based on demographic variables, such as race. This imagined community did not provide them with a sense of community that was as strong as other forms of community based on interacting with other gay men. The second form of community was an

institutional community that was created through membership to specific gay organisations, which provided individuals with the opportunity to experience community both emotionally and directly. The third form of community identified among these gay men was the community defined by their friends and friendship networks, often with other gay men or lesbians, which provided them with the strongest emotional bonds. Woolwine concluded that the lesser the universal nature of the definition that gay men used to define community, the more emotionally involved they were with that concept of community. Therefore, their personal experiences provided a stronger emotional attachment to a community than actual or perceived group experience.

The extent that gay men feel a part of the gay community varies depending on a number of factors (Chapple, Kippax, & Smith, 1998; Cody & Welch, 1997; Fraser, 2008; LeBeau & Jellison, 2009; Ridge, Plummer, & Peasley, 2006; Ridge, Minichiello & Plummer, 1997; Ridge, Hee, & Minichiello, 1999). The gay community in Australia, as it is generally currently defined, was a product of both the gay liberation movement of the 1970s and a collective response to the AIDS/HIV crisis (Chapple et al., 1998). An Australian qualitative study (Chapple et al., 1998) of older gay men found that those that were working class did not fit in with the inner city gay scene that is usually defined as the gay community. Instead, these men created their own community in their outer suburb area that was defined by their friendship network. Cody and Welch found that gay rural men in the US coped with the isolation that they experienced when they began to realise that they were gay, by relying on support from a “family of choice”. This family of choice consisted of friendship

networks of predominately other gay men and to a lesser extent lesbians and heterosexuals.

The results of Fraser's (2008) qualitative study of young Australian gay men indicated that there was a diverse array of opinions about the gay community, some quite negative. This researcher found that those young gay men who did not consider their sexuality a central part of their self-identity were less likely to speak favourably about the gay community. To some of the interview participants, gay community was fundamental to helping form their sense of being gay, while others argued that it perpetrated myths about gay men. Others combined both of these views to give a contradictory account of what the gay community meant to them. Most of the participants in this study viewed community as being a collection of similar individuals who cooperated to achieve common goals. This definition of community was seen by some as being supportive and enabling, so that it fostered a sense of belonging. To others this definition of community represented an impossible ideal that was disabling and excluded them from the gay community. Consequently, individuals who feel that they are different to the gay men that make up the gay community do not feel part of it. Fraser noted that the AIDS crisis helped bring the gay community together and now that this crisis has passed, it no longer plays a part in keeping this community together. In addition, Fraser argued that mainstream society has become more accommodating of gay men so that there are more options for gay men to socialise outside the gay community.

Similarly, LeBeau and Jellison's (2009) qualitative study of US gay and bisexual men found that there is diversity among participants on what defined the gay community and involvement in this community. Some of their participants,

defined the gay community as being both local and involving close friends, but many others defined it in terms that were more global and that it included lesbians, bisexuals, transgender, queer and questioning individuals. Although many participants reported that gay community activities involved both social and political activities, many also reported that it consisted of just one or the other. There was also considerable diversity in how they first encountered the gay community with many first doing so via friends and gay bars, but many first gained access through gay community centres and the internet. LeBeau and Jellison argued that this data suggested that for some individuals, altruism and activism are either of equal or greater importance than socialising in terms of being involved in the gay community. Some of these participants did not have positive first encounters with the gay community, with some experiences being either ambivalent or negative. They found that continued involvement in the gay community was motivated by anti-gay prejudice, despite this prejudice being seen as a disadvantage of gay community participation. In contrast not fitting in with the gay community was seen as both a disadvantage of this community and a reason not to be involved.

Two Australian qualitative studies found that although the gay scene in Australia created a space for multiple social networks to develop, some gay men struggled to fit in (Ridge et al., 1997; Ridge et al., 1999). Ridge et al. (1997) found that most gay man in their study struggled to establish a social network within the gay scene that provided social support. Their results indicated that older men, men from ethnic minorities, men with lower socio-economic status and men whose physical appearance did not meet trends, had the most difficulty establishing social networks. Men from some ethnic groups and lower socio-

economic status often experienced greater difficulty fitting into this gay scene due to not being familiar with the middle-class culture that dominated this scene (Ridge et al., 1997). Men from some ethnic backgrounds also faced the additional barrier of racial discrimination (Ridge et al., 1997). Similarly, Ridge et al. (1999) found that Asian men often felt pressure to assimilate within the Australian gay culture that was predominately white and middle class. These researchers found that Asian gay men who did not assimilate with this gay culture felt alienated.

An interview study by Ridge et al. (2006) exploring the experiences that Australian men had in developing their sexual identity, found that the gay scene played an important part in this process. This study found that this gay scene provided these men with a social space to discover new, predominately masculine, forms of embodiment, decoration and relating. This scene allowed them to have experiences that they could not have had elsewhere and it allowed them to develop social connections and see alternatives to conventional display of masculinity. Many of the men entering this scene appeared to have internalised the general community's view of masculinity so that some found the unconventional presentation of masculinity confronting. Additionally, there was a greater focus on the male body in this scene, which may have lead to men feeling more self-conscious about how they look or increase the perceived need for body perfection. Failure to conform to the social rituals of this scene could lead to others attacking the individual's self-esteem and finding them less sexually and socially attractive, but it was unlikely lead to violence. These scenes tended to allow a space for conventions associated with gender to be challenged. Not all the men in this study, however, found this scene satisfying

and many believed that they did not find a gay community. This process of becoming involved in a new social scene also involved giving up former aspects of self and embracing new social rituals and a sense of self.

A UK study (Hart & Fitzpatrick, 1990) found that gay men developed mutually supportive relationships. Most of the men in this study had told most of those that they knew about their sexual orientation. Moreover, all spent most of their social lives in the company of other gay men, with nearly the entire sample having others they could confide in. Most of these men did not live with a partner or a relative, but most felt that they could rely on those they knew to help them if they fell ill. One in four of the men in this sample had assisted a person suffering with HIV/AIDS. Most of these men assisted a close friend or an intimate partner who was suffering from this illness. These researchers argued that close intimate relationships are more important in providing care for gay men with AIDS/HIV than the wider gay community.

1.2.3. Summary of Risk and Protective Factors

In summary, many in the community have negative views about homosexuality (Kelley, 2001) and that many gay men experience discrimination, which adversely affects their mental health (Mays & Cochran, 2001). Research has established internalised homophobia as a risk factor for the onset of depression (Gold et al., 2007; Igartua et al., 2003). A possible protective factor that may prevent internalised homophobia developing into depression for some gay men is sense of belonging. Recent research has shown that sense of belonging to either the general or gay communities is related to lower levels of depression among gay men (McLaren et al., 2008). Woolwine (2000) has identified three separate forms of gay community, which are the wider gay

community, gay organisations and gay friendship networks. This contention that more than one form of gay community can potentially provide support to gay men is supported by the results of other studies (e.g., Fraser, 2008). It is proposed that sense of belonging to the general community, the gay community, gay organisations and gay friendship networks can act as protective factors in the internalised homophobia-depression relationship.

1.3. Resilience Models

One way to explore how sense of belonging to these various forms of community may influence the relationship between internalised homophobia and depression is to use resilience models (Garmezy, Masten, & Tellegen, 1984; Hollister-Wagner, Foshee, & Jackson, 2001; Masten et al., 1988). A man demonstrates *resilience* when he is capable of behaving adaptively when experiencing adversity (Hollister-Wagner et al., 2001). Researchers have developed and tested three basic models, the compensatory, risk-protective, and protective-protective models, to explore how resilience occurs (Garmezy et al., 1984; Hollister-Wagner et al., 2001; Masten et al., 1988).

The compensatory model predicts that both risk and protective factors have a direct influence on the outcome, so that the influence of the latter compensates for the former (Garmezy et al., 1984; Hollister-Wagner et al., 2001; Masten et al., 1988). In contrast, the risk-protective model predicts that the influence of the risk factor on the outcome is weakened by an interaction between the risk and protective factors (Garmezy et al., 1984; Hollister-Wagner et al., 2001). According to the protective-protective model the risk factor will interact with the number of protective factors that a man possesses, so that the

more protective factors he possesses, the less influence the risk factor has on the outcome (Hollister-Wagner et al., 2001).

As these resilience models were originally developed and used by researchers in the area of developmental and educational psychology (Garmezy et al., 1984; Hollister-Wagner et al., 2001; Masten et al., 1988), most of the samples in studies testing these models have consisted of children or adolescents (e.g., Christiansen & Evans, 2005; Evans, Marsh, & Weigel, 2010; Jackson & Frick, 1998). Only a small number of studies have tested these resilience models using adult samples, such as university students (Gomez & McLaren, 2006), the elderly (McLaren, Gomez, et al., 2007) and male farmers (McLaren & Challis, 2009). For example, McLaren, Gomez, et al. found in a sample of retired adults that there was support for some resilience models in explaining how two forms of sense of belonging, antecedents and psychological, affected the relationship between depression and suicidal ideation. The risk-protective model was supported for both genders when sense of belonging-psychological was the protective factor. Their results also supported the compensatory model, for women only, when sense of belonging-psychological was the protective factor. Additionally, they found support for the compensatory model for both men and women when the protective factor was the sense of belonging-antecedents.

1.4. Mediation Effects

Another model that may explain the relationship of internalised homophobia, sense of belonging and depression is the mediation model (Baron & Kenny, 1986). This model predicts that there is an indirect relationship between the independent variable and the outcome (Baron & Kenny, 1986). This indirect relationship occurs when the level of the independent variable influences the

level of a mediating variable (Baron & Kenny, 1986). The level of the mediating variable, so determined by the independent variable, in turn influences the dependent variable (Baron & Kenny, 1986). This model allows the independent variable to have a simultaneous direct relationship to the dependent variable despite the occurrence of this indirect relationship (Baron & Kenny, 1986). For this to occur, however, the presence of a mediating variable must significantly reduce the direct relationship between independent and dependent variables (Baron & Kenny, 1986).

1.5. Aims and Hypotheses

Research that identifies factors that protect an individual from experiencing negative consequences due to internalised homophobia is essential for the development of interventions to assist gay men to manage their experience of stigma (Szymanski & Kashubeck-West, 2008). The intended purpose of this study was to gain a greater understanding of how internalised homophobia and sense of belonging to the general community, the gay community, gay organisations and gay friends influence depressive symptoms in gay men.

1.5.1. Aim 1 and Hypotheses

The first aim of this study was to determine if levels of depressive symptoms in a sample of self-identified gay men varied due to levels of internalised homophobia and sense of belonging to the general community, the gay community, gay organisations and gay friendships. It was hypothesised that internalised homophobia will have a direct negative influence on the level of depressive symptoms that gay men experience. It was also hypothesised that sense of belonging to the general community, the gay community, gay

organisations and gay friendships would each have a direct positive influence on the level of depressive symptoms experienced by gay men.

1.5.2. Aim 2 and Hypotheses

The second aim of this study was to test the effectiveness of various resilience models in explaining the relationship between depressive symptoms, internalised homophobia and sense of belonging to the general community, the gay community, gay organisations and gay friends in a sample of self-identified gay men. For the compensatory model, it was hypothesised that internalised homophobia would be positively associated with the level of depressive symptoms, whereas sense of belonging to the general community, the gay community, gay organisations and gay friendships would each be negatively associated with the level of depressive symptoms. Consistent with the risk-protective model, it was hypothesised that having higher levels of sense of belonging to the general community, the gay community, gay organisations and friendship networks would each reduce the influence of internalised homophobia on depressive symptoms. For the protective-protective model, it was hypothesised that as the number of protective factors increased, the relationship between internalised homophobia and depressive symptoms would weaken.

1.5.3. Aim 3 and Hypothesis

The third aim of this study was to determine if there were any mediation effects present. To achieve this aim both direct and indirect relationships between internalised homophobia and depressive symptoms were tested in a sample of self-identified gay men. McLaren et al. (2008) found that the sense of belonging to the general community partially mediated the relationship between sense of belonging to the gay community and depression. Woolwine's (2000)

qualitative study indicated that in addition to the global gay community explored by McLaren et al., there were two other forms of gay community, gay organisations and gay friends. Sense of belonging to these two spheres of community was added to the McLaren et al. mediation model. In the model, sense of belonging gay community, gay organisations and gay friends were expected to have an indirect relationship with depressive symptoms via sense of belonging general community.

There is substantial support in the literature of a direct relationship between internalised homophobia and depression, among gay men (e.g., Frost & Meyer, 2009). Additionally, internalised homophobia has been associated with not joining gay groups (Ross & Rosser, 1996), less acculturation to the gay or general communities (Ratti et al., 2000) and coming from families or communities not accepting of gay men (Preston et al., 2007). It was decided, therefore, to determine if sense of belonging to different spheres of community mediated the relationship between internalised homophobia and depression. This was achieved by adding a direct path from internalised homophobia to sense of belonging gay community, gay organisations and gay friends, as well as a direct path between internalised homophobia and depressive symptoms.

It was hypothesised that internalised homophobia would directly influence depressive symptoms. It was also hypothesised that internalised homophobia would directly influence sense of belonging to the gay community, gay organisations and gay friendships and that these three forms of sense of belonging would directly influence sense of belonging to the general community, which in turn would predict depressive symptoms. The proposed model can be seen in Figure 1.

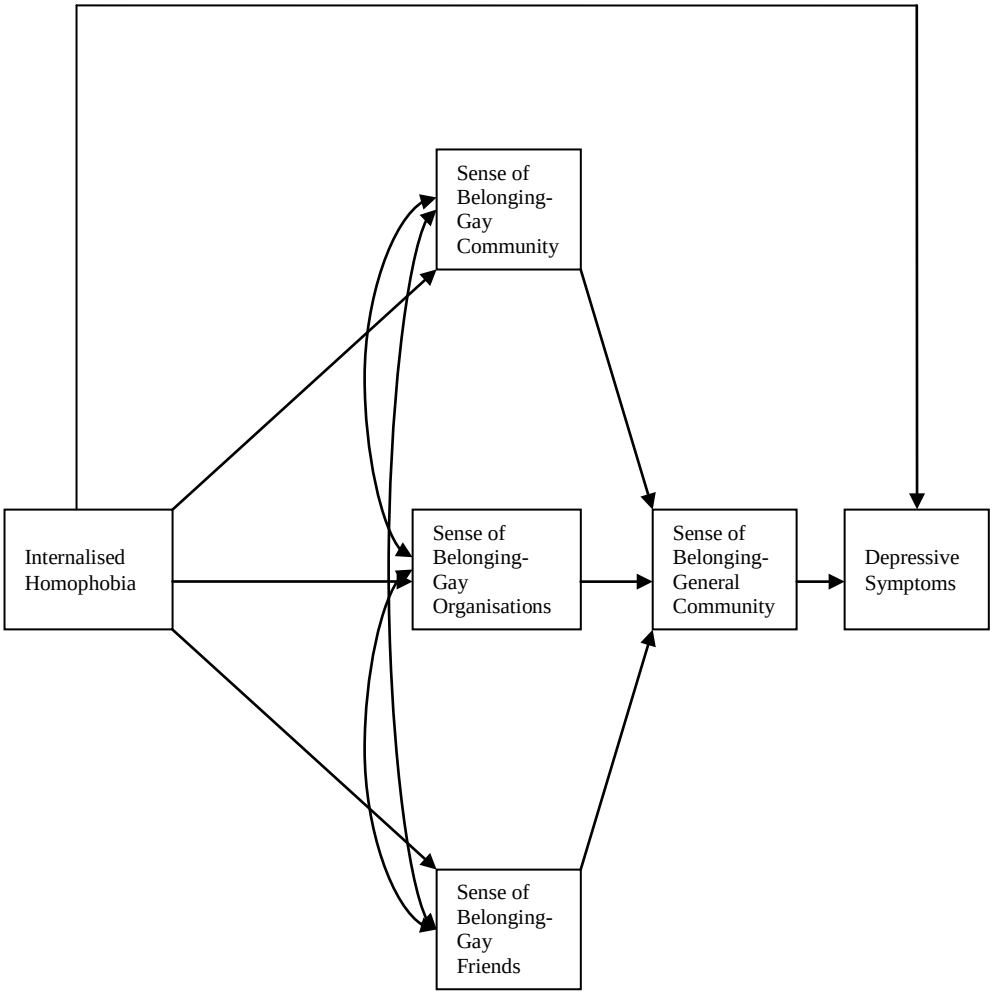


Figure 1. Hypothesised path model predicting depressive symptoms.

Chapter 2: Method

2.1. Participants

The sample for this study consisted of 246 men, aged between 18 and 82 years (M = 35.37, SD = 12.42), who self-identified as gay. The details of the sample can be seen in Table 1. When this data was compared to the Australian general population (Australian Bureau of Statistics, 2010) the sample was better educated with almost two thirds successfully completing a bachelor degree or higher compared to almost a quarter of general population. About a third of the participants was earning less than $40,000 per year or was earning more than $60,000 per year. Two thirds of the sample, therefore, was earning either well below or above the average Australian yearly income, in May 2010, of approximately $50,000 (Australian Bureau of Statistics, 2011a). There were similar rates of full-time employment in the present sample and the general population with about two thirds of both samples working full-time (Australian Bureau of Statistics, 2007b). Slightly fewer gay men in the sample (19.56%) than the general population (27.9%) worked part-time (Australian Bureau of Statistics, 2007b). The proportion of unemployed in the sample (10.60%) was twice that of the general population (5.1%; Australian Bureau of Statistics, 2011b). There are difficulties in comparing the relationship status of the gay men in the present study to relationship status in the 2006 census (Australian Bureau of Statistics, 2007b). The latter is focused on marriage and very few of the gay men in the study were married or had been married. The proportion of the sample partnered, however, is similar to the proportion of the general population who are married, about 50% (Australian Bureau of Statistics, 2007b).

Table 1

Frequency of Demographic Characteristics in Sample (*N* = 246)

Variable	*N*	%
Disclosure		
<25%	18	7.30
25% to 50%	19	7.70
51-75%	60	24.40
>75%	149	60.60
Relationship Status		
Partnered	125	50.80
Single	106	43.10
Married	1	0.40
Separated/Divorced	9	3.70
Widowed	1	0.40
Other	4	1.60
Highest Level of Education		
Secondary/TAFE	102	41.50
Undergraduate	77	31.30
Postgraduate	67	27.20
Current Employment Status		
Full Time	148	60.20
Part Time	48	19.50
Unemployed	26	10.60
Retired	8	3.30
Other	16	6.50
Income per annum		
<$10,000	28	11.40
$10,000-$19,999	28	11.40
$20,000-$29,999	10	4.10
$30,000-$39,999	35	14.20
$40,000-$49,999	30	12.20
$50,000-$59,999	32	13.00
$60,000-$69,999	24	9.80
>$70,000	59	24.00

2.2. Materials

The participants in this study completed a questionnaire package consisting of a plain language statement, demographic questionnaire, Center for Epidemiological Studies–Depressive Scale (Radloff, 1977), the Internalized Homophobia Scale (Wagner, 1998), the Sense of Belonging Instrument (Hagerty & Patusky, 1995) and four visual analogue scales.

2.2.1. Plain Language Statement

The Plain Language Statement (Appendix A) outlined the purpose of the study and the requirements of participation in this study. This statement also contained contact numbers of the researchers and the Gay and Lesbian Switchboard for participants who felt the need to initiate contact as the result of their participation in this study.

2.2.2. Demographic Questionnaire

The questionnaire used to collect demographic information from the participants (Appendix B), contains items asking about gender, sexual identity, proportion of people who know about their sexuality, age, residential postcode, relationship status, highest education level successfully completed, current employment status and income per annum. Sexual identity was assessed by asking participants: *What do you consider your sexuality to be?* Participants responded to this item by selecting one of *Gay Male*, *Lesbian*, *Bisexual*, *Queer*, *Don't know*, *Straight* or *Other*. The participants' level of outness was assessed by asking: *What percentage of people that you know are aware of your sexual orientation?* The participants selected one of the following as their response: *less than 25%*, *25% to 50%*, *51% to 75%* or *more than 75%*.

2.2.3. Center for Epidemiological Studies–Depressive Scale

The level of depressive symptoms experienced by the men in the past week was measured using the Center for Epidemiological Studies–Depressive Scale (Radloff, 1977; Appendix C). This questionnaire contains 20 items (e.g., *I thought my life had been a failure*). Participants indicate the proportion of time that they experienced each item by using a 4-point scale, from 1 = *Rarely or*

None of the time (less than 1 day) to 4 = *Most or All of the time (5-7 days).* Higher scores indicate higher levels of depressive symptoms (Radloff, 1977).

The Center for Epidemiological Studies–Depressive Scale is positively correlated with functional impairment and number of diseases (Lewinsohn, Seeley, Roberts, & Allen, 1997). An adequate test-retest reliability for this questionnaire after 2.4 years between tests was found for adults aged 50 years and over (r = .52; Lewinsohn et al., 1997). Similarly, another study found test-retest reliability of this measure was adequate after 3 and 12 months between tests for a sample adult homeless people (r = .56; Wong, 2000). Research indicates that it has adequate internal reliability for adults aged 50 years and over (α = .82; Lewinsohn et al., 1997) and adult homeless people (α = .89; Wong, 2000). The Cronbach's alpha for this measure was calculated for the current sample (α = .91).

2.2.4. Internalized Homophobia Scale

The Internalized Homophobia Scale (Wagner, 1998; Appendix D) consists of 20 items and measures how much an individual's self-image and gay identity have been influenced by the internalisation of anti-gay attitudes and beliefs (e.g., *I wish I were heterosexual*). Participants indicate how much they agree with an item by using a 5 point scale, from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores on this scale indicate higher levels of internalised homophobia (Wagner, 1998).

Studies have also found that it is positively correlated with demoralisation (r = .49), global psychological distress (r = .37) and depression (r = .36; Wagner, Serafini, Rabkin, Remien, & Williams, 1994). It is also positively correlated with the age at which an individual accepted being gay (r =

.46) and is negatively correlated with how integrated the individual is with the gay community (r = -.54; Wagner et al., 1994). Research indicates that the Internalized Homophobia Scale (Wagner, 1998) has adequate internal reliability with a study of 142 gay men finding a Cronbach's alpha of .92 (Wagner et al., 1994). Cronbach's alpha for this measure was calculated for the current sample (α = .92).

2.2.5. Psychological Subscale of the Sense of Belonging Instrument

The Psychological Subscale of the Sense of Belonging Instrument (Hagerty & Patusky, 1995) has 18 items, measuring the respondent's perception of their sense of belonging (*e.g., I am just not sure if I fit in with my friends*). The participant indicates using a four-point scale, from 1 = *strongly disagree* to 4 = *strongly agree*, how much each item applies to them, with higher scores on this measure indicating a higher level of psychological sense of belonging (Hagerty & Patusky, 1995).

In their study, Hagerty and Patusky (1995) found that nuns had significantly higher scores on the sense of belonging inventory-psychological subscale, than either depressive patients or students, and students scored significantly higher than the depressive patients. These researchers found a positive correlation between this subscale with measures of social support, with correlations for the three groups ranging from r = .42 to r = .58. They also found that positive correlations between this measure and reciprocity for the three groups ranged from r = .22 to r = .59 and negative correlations between this measure and loneliness, ranged from r = -.62 to r = -.72. The test-retest reliability for the student group, in their study, after an eight-weeks between tests was r = .84. Their results also indicate that the subscale has high internal

consistency for each of the three groups in their study, with Cronbach's alphas ranging between α = .91 and α =.93.

The sense of belonging inventory-psychological subscale was used to measure sense of belonging to the general and gay communities, so that each participant completed this measure twice, once in reference to their experiences with the general community (Appendix E) and once in reference to their experiences with the gay community (Appendix F). To create two different versions of the sense of belonging inventory-psychological subscale, one measuring sense of belonging to the general community and the other to the gay community, the wording of some items were altered. For example, the item *I often wonder if there is any place on earth where I really fit in* was changed to *I often wonder if there is any place in the general community where I really fit in* and *I often wonder if there is any place in the gay community where I really fit in*. The same Cronbach's alpha for the current sample was found for sense of belonging inventory-psychological subscale for the general community and the gay community (α = .95).

2.2.6. Sense of Belonging Visual Analogue Scales

Twelve visual analogue scales, similar to those used in a Doctorate thesis (Morris, 2010; Appendix G), were used to measure sense of belonging to the general community, gay community, gay organisations and gay friendship networks. Visual analogue scales are used by researchers and clinicians to measure internal experiences of an individual, such as feelings and perceptions (Lee & Kieckhefer, 1989; Lisher, Cooter, & Zald, 2008). Research has demonstrated that visual analogue scales are linear response measures of a latent variable (Hofmans & Theuns, 2008).

The participants were asked to indicate the extent to which they felt that they were a valued member of each community and if they feel they fit in with other members. For example the two items on the VAS measuring sense of belonging to the gay community are: *Thinking about the gay community in general, to what extent do you feel needed or valued?* and *Thinking about the gay community in general, to what extent do you feel that you fit in?* For the VAS items, measuring sense of belonging to other three communities, *gay community in general* is replaced with *general community*, *gay organisations* or *gay friends*. The participants responded to each question using a 10-point scale, with lower scores indicating feelings of being less needed or valued or not fitting in well, for the respective items. The higher scores on the items indicated a feeling of being more needed or valued or fitting in well, for the respective items. The exact wording of lowest and highest values of this 10 point scale for the first item was 0 = *not needed or valued* to 10 = *completely valued*. For the second item the labels for the highest and lowest values were 0 = *do not fit in at all* to 10 = *completely fit in*.

2.3. Procedure

Ethics approval was sought and gained from the University of Ballarat Human Research Ethics Committee. The researcher attended gay festivals with the permission of the organisers. Questionnaires were distributed for this study from a table that had signs advertising both the study and the university. An incentive that consisted of a bag of lollies was provided to each participant who completed a questionnaire at these gay festivals and most questionnaires were completed returned to the researcher at that time. In some cases, participants took uncompleted questionnaires home with them and returned the completed

questionnaires via post. Five hundred questionnaires were distributed with 304 being returned, a return rate of 60.80%. The order of questionnaires was counterbalanced, by differing in the order that each questionnaire was presented.

2.4. Data Analyses

2.4.1. Preliminary Analyses

Means and standard deviations were calculated to explore the variables of interest. Additionally, analyses were conducted to determine if the assumptions of various statistical tests were met. Research has indicated that disclosure of sexual minority status (Frost et al., 2007), age (Australian Bureau of Statistics, 2007a; Bybee et al., 2009; Scott, Browne, & Wells, 2010; Wells et al., 2006), relationship status (Australian Bureau of Statistics, 2007a), educational attainment (Huebner, Nemeroff, & Davis, 2005; Perdue, Hagan, Thiede, & Valleroy, 2003) and income (Australian Bureau of Statistics, 2007a; Perdue et al., 2003; World Health Organization, 2004) can independently influence depression. To determine if any of these demographic characteristics were independently influencing depressive symptoms in this sample, a correlation matrix was calculated. Those demographic characteristics that were significantly influencing depressive symptoms were subsequently controlled for when testing the hypothesis.

2.4.2. Aim 1 Data Analyses

A correlation matrix was formed to determine if there were any direct relationships between the outcome variable of depressive symptoms and the risk factor of internalised homophobia, or the protective factors of sense of belonging to the general community, gay community, gay organisations and gay friends. A significant correlation, between depressive symptoms and the risk factor, or

depressive symptoms and any of the protective factors indicated support for the direct effects model.

2.4.3. Aim 2 Data Analyses

Multiple regression methods developed by Garmezy et al. (1984) were used to test the resilience models. Following the suggestion of Cohen and Cohen (1983), the problem of multicollinearity was avoided by using interaction terms derived from centred scores. These centred scores were created, as Cohen and Cohen suggested, by subtracting the mean from actual score.

The compensatory and the risk-protective models was tested in a three-step regression for each of the protective factors, sense of belonging to the general community, gay community, gay organisations and gay friends. Covariates were added in Step 1. In Step 2 the outcome variable, depressive symptoms, was regressed on the risk factor, internalised homophobia and on the protective factor being tested. If both risk factor and protective factor significantly predicted outcome, in Step 2, then there was support the compensatory model. In Step 3 of the regression, the interaction term of risk factor x protective factor was added. A significant change R^2 statistic for Step 3 provided support for the risk-protective model.

The protective-protective model was tested in a separately from the other two variables, using regression analysis. Following a procedure previously used in research (Gomez, & McLaren, 2006; McLaren & Challis, 2009; McLaren et al., 2001), the number of protective factors each participant had was calculated based on their sense of belonging to the general community, gay community, gay organisations and gay friends scores. A score of 1 was given to each participant who scored equal to or higher than the mean of the sample on a specific

protective factor. Those with a score on a specific protective factor lower than the mean were given a score of 0. In this way, the total number of protective factors for each participant was calculated by tallying all of the 0s or 1s the individual received. This resulted in each participant receiving a score of between 0 and 4, indicating the number of protective factors that he had. To test the protective-protective model depressive symptoms was regressed on internalised homophobia, number of protective factors, internalised homophobia x number of protective factors, internalised homophobia x internalised homophobia and internalised homophobia x internalised homophobia x number of protective factors (Garmezy et al., 1984). The protective-protective model was supported if internalised homophobia x number of protective factors significantly predicted depressive symptoms.

2.4.4. Aim 3 Data Analyses

Path analysis was used to investigate a hypothesised model of how several variables are thought to be related to each other, in order to determine if these variables are associated (Cramer, 2003; Foster, Barkus and Yavorsky, 2006; Kline, 2005). In this way, the influence of independent variables on the dependent variable can be explored, as well as how the independent variables relate to each other (Foster et al., 2006). The path analyses used in this study were calculated using estimators based on the maximum likelihood method (Muthen & Muthen, 2007). All path analyses calculations were performed using Mplus version 5.1 (Muthen & Muthen, 2007).

To test the fit of a proposed model, statistically, chi-square (χ^2) is often used (Kline, 2005; Hu & Bentler, 1998, 1999). This statistic is generated by comparing the covariance matrix produced by the sample data to a hypothesised

covariance matrix that is intended to represent the actual population of interest (Kline, 2005; Hu & Bentler, 1998, 1999). If χ^2 is significant then the sample covariance matrix is considered not to fit the hypothesised model (Kline, 2005; Hu & Bentler, 1998, 1999). The significance of χ^2, however, can be adversely affected by small or large sample sizes (Hu & Bentler, 1998, 1999; Kline, 2005) or when assumptions of normality are violated (Hu & Bentler, 1998).

In an attempt to overcome the limitations of χ^2, various fit indices have been proposed (Hu & Bentler, 1998, 1999). These fit indices quantify the level of fit along a continuum and are a summary statistic similar to R^2 that is intended to quantify something rather than test a hypothesis (Hu & Bentler, 1998). These fit indices are intended to compliment χ^2 when determining goodness of fit, rather than replace this statistic (Hu & Bentler, 1998). These fit indices are also affected by sample size, with samples, like the present study, with fewer than 250 participants having an increased likelihood of Type I and Type II errors (Hu & Bentler, 1998, 1999). Yuan (2005) argued that variables such as the sample size and distribution of data affect the covariance matrix and model structure, these variables also affect both the distribution and mean of the fit indices. This researcher contended that cut-off scores for fit indices, therefore, are always open to doubt. Another issue that affects the interpretation of fit indices is that the value of a fit index is an indicator of average fit of the model, so that some parts of a model may be a better fit than others (Kline, 2005). Due to these issues, researchers recommend assessing the goodness of fit, by using more than one fit index (Hu & Bentler, 1998, 1999; Kline, 2005). Cut-off scores that have been recommended based on empirical research (Hu & Bentler, 1998, 1999) are only

intended to guide decision making about fit, not act as absolute rules (Hu & Bentler, 1998, 1999; Marsh, Hau, & Wen, 2004).

In the current study, the following fit indices were used: the Comparative Fit Index (CFI), Tucker Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA) and Standardised Root Mean Square Residual (SRMR). Both the CFI and the TLI are examples of incremental fit index measures that are calculated by comparing the intended model to a model that is more restricted (Hu & Bentler, 1998, 1999; Kline, 2005). Hu and Bentler (1998, 1999) have argued, based on their empirical testing of various cut-off scores with non-normal data, scores higher than .95 for the CFI and the TLI indicate good fit. Their research results also indicated that the TLI is less well suited for small samples ($N \leq 250$) than the CFI (Hu & Bentler, 1998, 1999). In contrast, the RMSEA and the SRMR are examples of absolute fit indices that are calculated by testing how well the sample data is represented by a priori model (Hu & Bentler, 1998, 1999; Kline, 2005). According to Hu and Bentler (1998, 1999) scores lower than .06 and .08 on the RMSEA and SRMR, respectively indicate good fit. Although, the accuracy of the RMSEA is affected by sample size (Curran, Bollen, Chen, Paxton, & Kirby, 2003; Hu & Bentler, 1998, 1999; Kline, 2005), it has been empirically demonstrated to be unaffected when samples are larger than 200 (Curran et al., 2003). Based on their empirical testing of the various fit indices, Hu and Bentler (1998) concluded that the SRMR is the most robust of the fit indices and they recommended making decisions using this index and at least one other index.

Chapter 3: Results

3.1. Preliminary data analysis

3.1.1. Data Screening

Three hundred and four questionnaires were returned. Twenty-two participants were excluded for responding in a way that probably did not indicate an accurate response to the questionnaire. For example, some of these participants used the same numbered response for every item on a questionnaire even though some items were phrased positively and others negatively. Another 32 men were excluded for excessive amounts of missing data on the variables of interest and four were excluded, as they did not provide key demographic information. After these questionnaires were removed from the sample, there were 246 participants left. As a number of the remaining participants had one or two values missing from specific questionnaires, these values were replaced by their average score on items for that questionnaire (Green, Salkind, & Akey, 2000).

3.1.2. Descriptive Statistics

Descriptive statistics were generated for each of the variables of interest. These results are shown in Table 2.

Table 2

Descriptive Statistics for the Variables of Interest (*N* = 246)

Variable	*M*	*SD*
Depressive symptoms	34.82	10.98
Internalised Homophobia	38.46	13.39
SOBI for the General Community	53.36	10.46
SOBI Gay Community	53.32	10.58
SB – General Community VAS	13.25	4.55
SB – Gay Community VAS	12.85	4.60
SB – Gay Organisations VAS	12.33	4.89
SB – Gay Friends VAS	14.66	4.44
# Protective Factors	2.04	1.50

Note. SB = Sense of Belonging.

3.1.3. Control Variables

To determine if any demographic variables were related to depressive symptoms in this sample of gay men, correlations were calculated between these variables and depressive symptoms. Results are presented in Table 3. There are weak but significant correlations between depressive symptoms and disclosure, age and income. It was decided to control for the influence of these three variables during subsequent regression analyses.

Table 3

Pearson's Correlation Coefficients between Depressive symptoms and Demographic Variables often associated with Depressive symptoms (*N* = 246)

Variable	1	2	3	4	5	6
1. Depressive symptoms	-	-.19**	-.18**	-.12	-.06	-.18**
2. Disclosure		-	.06	-.02	-.07	.09
3. Age			-	-.05	.23***	.25***
4. Relationship Status [a]				-	-.02	-.15*
5. Highest Level of Education					-	.38***
6. Income per annum						-

[a] 1= partnered, 2 = un-partnered.

*p < .05. **p < .01. ***p < .001.

3.1.4. Assumption Testing

Table 4 contains the results of the exploratory analysis of the variables of interest to determine their level of skew and kurtosis. As the results presented in this table indicate, sense of belonging inventory-psychological subscale -General Community, sense of belonging inventory-psychological subscale -Gay Community, Sense of Belonging Gay Community VAS, Sense of Belonging Gay Organisations VAS and the Number of Protective Factors all had an acceptable level of skew. However, Depressive symptoms, Internalised Homophobia, Sense of Belonging General Community VAS and Sense of Belonging Gay Friendships VAS were excessively skewed. A square-root transformation was applied to each of these variables, which reduced the skew to more acceptable levels. These transformed variables were used in all subsequent analyses.

Table 4

Skew and Kurtosis Z Scores Before and After Transformation Procedures (*N* = 246)

Variable	Skew (*z*)	Kurtosis (*z*)	Transformation	Skew (*z*)	Kurtosis (*z*)
Depressive symptoms	5.39	0.52	Square root	3.59	-1.51
Internalised Homophobia	4.57	-1.35	Square root	2.92	-2.50
SOBI-P-General Community	-0.61	-0.64	None	-	-
SOBI-P-Gay Community	-0.15	-0.96	None	-	-
SB- General Community VAS	-4.43	-0.85	Square root	-0.13	-1.50
SB- Gay Community VAS	-2.93	-1.59	None	-	-
SB- Gay Organisations VAS	-2.08	-2.23	None	-	-
SB- Gay Friendships VAS	-5.93	-1.09	Square root	-1.33	-2.08
# Protective Factors	0.07	-4.59	None	-	-

Note. SOBI-P= Sense of Belonging Inventory-Psychological subscale, SB = Sense of Belonging, VAS = Visual Analogue Scale

3.1.5. Visual Analogue Scales

Before testing the hypothesis a number of analyses were undertaken to determine if the visual analogue scales used to measure sense of belonging to specific communities were measuring this construct adequately. The sense of belonging inventory-psychological subscale was slightly modified in this study to measure sense of belonging to the gay community as well as the general community. Correlations between the two versions of the sense of belonging inventory-psychological subscale, r (244) = .62, p = .01, indicated that there was a large amount of shared variance in the responses to these two versions of the subscale. Despite this, the correlation between the two measures was not perfect. This lack of perfect correlation suggested that the participants were responding differently to each version of the subscale, in reference to two different communities.

Sense of belonging to the general community as measured by the sense of belonging inventory-psychological subscale was found to be significantly positively correlated to sense of belonging general community VAS, r (244) = .68, $p < .001$. Pearson's correlation coefficients were also calculated between the sense of belonging inventory-psychological subscale for gay community and sense of belonging gay community VAS, r (244) = .75, $p < .001$. These strong positive correlations between two different measures of sense of belonging to a specific community indicate that both the sense of belonging general community VAS and the sense of belonging gay community VAS provide adequate estimation of sense of belonging to these communities.

The correlation was calculated for sense of belonging inventory-psychological subscale for general community and sense of belonging gay community VAS, r (244) = .45, $p < .001$, and between the sense of belonging inventory-psychological subscale for gay community and sense of belonging general community VAS, r (244) = .49, $p < .001$. The weaker correlation between the sense of belonging inventory-psychological subscale and VAS measuring sense of belonging to different communities than the correlation between the sense of belonging inventory-psychological subscale and VAS measuring the same community sense of belonging, indicates that these VAS measures do in fact measure different communities.

It was not possible to compare the sense of belonging gay organisations VAS and the sense of belonging gay friends VAS to a comparable sense of belonging inventory-psychological subscale. However, both of these measure correlated more strongly with the sense of belonging inventory-psychological subscale gay community, r (244) = .66, $p < .001$; r (244) = .62, $p < .001$,

respectively, than they did with sense of belonging inventory-psychological subscale general community, r (244) = .42, $p < .01$; r (244) = .45, $p < .001$, respectively. This result is consistent with gay community, gay organisations and gay friends all requiring the participants to think about their interactions with other gay men. Given these results, there is some indication that both the sense of belonging Gay organisations VAS and the sense of belonging gay friends VAS, in the absence of comparable psychometric measures, are reasonable estimates of sense of belonging to these communities. It was decided to use these measures in testing the hypotheses. It was also decided to use the sense of belonging inventory-psychological subscale measures for the general community and the gay community. The decision to use these modified subscales was due to the high levels of internal reliability for these measures for this sample.

3.2. Aim 1 Hypotheses Testing

Table 5 shows the Pearson's correlation coefficients between each of the variables of interest, as well as the partial correlations between these variables when controlling for disclosure, age and income. The results indicate all variables were significantly correlated with each other, with the risk factor internalised homophobia being positively correlated with depressive symptoms and all of the protective factors having a negative correlation with depressive symptoms. The partial correlations were all significant indicating that the relationship between depressive symptoms and the other variables remain significant when disclosure, age and income are held constant. These results provide support for the direct effect models.

Table 5

Partial-Correlations and Pearson's Correlation Coefficients between Variables of Interest (N = 246)

Variable	1	2	3	4	5	6
1.Depressive symptoms	-	.37***	-.55***	-.48***	-.32***	-.41***
2.Internalised Homophobia	.31***	-	-.47***	-.44***	-.22***	-.39***
3.SB–General Community	-.52***	-.39***	-	.62***	.42***	.45***
4.SB–Gay Community	-.44***	-.35***	.58***	-	.66***	.62***
5.SB–Gay Organisations	-.30***	-.15***	.40***	.65***	-	.55***
6.SB–Gay Friends	-.37***	-.31***	.40***	.59***	.54***	-

Note. SB = Sense of Belonging. Partial Correlations appear, below diagonal and correlations above diagonal.

*$p < .05$. **$p < .01$. ***$p < .001$.

3.3. Aim 2 Hypotheses Testing

The results of testing for the compensatory and risk-protective models, using Sense of Belonging to the General Community, as the protective factor, when controlling for disclosure, age and income, are shown in Table 6. The demographic variables accounted for 7% of variance in depressive symptoms scores. The addition of Internalised Homophobia and Sense of Belonging to the General Community accounted for a further 26% of variance in depressive symptoms scores. As can be seen in Table 6 both Internalised Homophobia and Sense of Belonging to the General Community are significant predictors of depressive symptoms. The compensatory model, therefore, is supported. The addition of the interaction term at Step 3 did not explain any additional variance in depressive symptoms scores. The results do not support the risk-protective model. The final model accounted for 33% of the variance in depressive symptoms scores, $F(6, 239) = 20.62$, $p < .001$. In the final model, higher levels

of sense of belonging to the general community and lower levels of internalised homophobia were related to lower levels of depressive symptoms.

Table 6

Results of the Analyses for Testing the Compensatory and Risk-Protective Models Involving Sense of Belonging – General Community as a Protective Factor (N = 246)

	b	*SE*	*β*	*t*
Step 1 [R^2 = .08, adjusted R^2 = .07, F (3, 242) = 7.16***]				
Disclosure	-0.17	0.06	-.17	-2.81**
Age	-0.01	0.01	-.14	-2.21 *
Income	-0.05	0.02	-.13	-1.97
Step 2 [ΔR^2 = .26, adjusted R^2 = .33, ΔF(2, 240) = 46.98***]				
Disclosure	0.02	0.06	.02	0.37
Age	-0.01	0.00	-.08	-1.53
Income	-0.03	0.02	-.08	-1.40
Internalised Homophobia	0.13	0.06	.15	2.16 *
Sense of Belonging–General Community	-0.04	0.01	-.47	-7.88***
Step 3 [ΔR^2 = .00, adjusted R^2 = .33, ΔF(1, 239) = 0.44]				
Disclosure	0.03	0.06	.03	0.44
Age	-0.01	0.00	-.09	-1.61
Income	-0.03	0.02	-.08	-1.38
Internalised Homophobia	0.12	0.06	.14	2.06 *
Sense of Belonging–General Community	-0.41	0.01	-.48	-7.89***
Internalised Homophobia x Sense of Belonging–General Community	-0.00	0.00	-.04	-0.66

*p < .05. **p < .01. ***p < .001.

Table 7 summarises the results of testing for the compensatory and risk-protective models, when Sense of Belonging to the Gay Community is the protective factor and when controlling for disclosure, age and income.

Table 7

Results of the Analyses for Testing the Compensatory and Risk-Protective Models Involving Sense of Belonging – Gay Community as a Protective Factor (N = 246)

	b	*SE*	*β*	*t*
Step 1 [R^2 = .08, adjusted R^2 = .07, F (3, 242) = 7.16***]				
Disclosure	-0.17	0.06	-.17	-2.81**
Age	-0.01	0.01	-.14	-2.21 *
Income	-0.05	0.02	-.13	-1.97
Step 2 [ΔR^2 = .20, adjusted R^2 = .28, ΔF(2, 240) = 34.02***]				
Disclosure	0.03	0.06	.03	0.50
Age	-0.01	0.00	-.08	-1.42
Income	-0.03	0.02	-.09	-1.54
Internalised Homophobia	0.17	0.06	.20	2.91**
Sense of Belonging–Gay Community	-0.03	0.01	-.38	-6.02***
Step 3 [ΔR^2 = .00, adjusted R^2 = .27, ΔF(1, 239) = 0.15]				
Disclosure	0.03	0.07	.03	0.43
Age	-0.01	0.00	-.08	-1.33
Income	-0.03	0.02	-.09	-1.56
Internalised Homophobia	0.15	0.09	.18	1.74
Sense of Belonging–Gay Community	-0.03	0.01	-.38	-6.02***
Internalised Homophobia x Sense of Belonging–General Community	0.00	0.01	.04	0.39

*p < .05. **p < .01. ***p < .001.

Seven percent of variance in depressive symptoms scores accounted for by the demographic variables. The amount of variance in depressive symptoms scores accounted for increased by 20% when Internalised Homophobia and Sense of Belonging to the Gay Community were added in step 2. As the results in Table 7 show that both Internalised Homophobia and Sense of Belonging to the Gay Community significantly predicted depressive symptoms, supporting the compensatory model. No additional variance in depressive symptoms scores was explained by adding the interaction term in Step 3. These results do not provide support for the risk-protective model. The final model explained 27% of the variance in depressive symptoms scores, $F(6, 239) = 15.86$, $p < .001$. As indicated by this final model higher levels of sense of belonging to the gay community were related to lower levels of depressive symptoms, but lower levels of internalised homophobia was not associated with depressive symptoms.

Presented in Table 8 are the results of testing for the compensatory and risk-protective models, when controlling for disclosure, age and income, with the protective factor of Sense of Belonging to Gay Organisations. The demographic variables explained 7% of variance in depressive symptoms scores. With the addition of Internalised Homophobia and Sense of Belonging to the Gay Organisations, in Step 2, the amount of variance in depressive symptoms scores explained by the model increased by 15%. Additionally, both Internalised Homophobia and Sense of Belonging to the Gay Organisations significantly predicted depressive symptoms in Step 2. These results support the compensatory model. There was no support for the risk-protective model, as adding the interaction term in Step 3 did not explain any additional variance in depressive symptoms scores. Twenty three percent of the variance in depressive

symptoms scores was explained by the final model, $F(6, 239) = 11.84$, $p < .001$. As indicated by this final model, lower levels of depressive symptoms were associated with higher levels of income, higher levels of sense of belonging to gay organisations and lower levels of internalised homophobia.

Table 8

Results of the Analyses for Testing the Compensatory and Risk-Protective Models Involving Sense of Belonging – Gay Organisations as a Protective Factor ($N = 246$)

	b	*SE*	*β*	*t*
Step 1 [$R^2 = .08$, adjusted $R^2 = .07$, F (3, 242) = 7.16***]				
Disclosure	-0.17	0.06	-.17	-2.81**
Age	-0.01	0.01	-.14	-2.21 *
Income	-0.05	0.02	-.13	-1.97
Step 2 [$\Delta R^2 = .15$, adjusted $R^2 = .23$, $F(2, 240) = 22.96$***]				
Disclosure	0.03	0.07	.03	0.45
Age	-0.01	0.00	-.08	-1.32
Income	-0.05	0.02	-.14	-2.34 *
Internalised Homophobia	0.27	0.06	.31	4.52***
Sense of Belonging–Gay Organisations	-0.05	0.01	-.25	-4.32***
Step 3 [$\Delta R^2 = .00$, adjusted $R^2 = .23$, $F(1, 239) = 0.83$]				
Disclosure	0.03	0.07	.03	0.45
Age	-0.01	0.00	-.08	-1.25
Income	-0.05	0.02	-.14	-2.33 *
Internalised Homophobia	0.27	0.06	.31	4.52***
Sense of Belonging– Gay Organisations	-0.05	0.01	-.25	-4.27***
Internalised Homophobia x Sense of Belonging–Gay Organisations	0.02	0.01	.01	0.19

*$p < .05$. **$p < .01$. ***$p < .001$.

The results presented in Table 9 are for testing the compensatory and risk-protective models, when controlling for disclosure, age and income and using Sense of Belonging to Gay Friendships as the protective factor.

Table 9

Results of the Analyses for Testing the Compensatory and Risk-Protective Models Involving Sense of Belonging – Gay Friendships as a Protective Factor (N = 246)

	b	*SE*	*β*	*t*
Step 1 [R^2 = .08, adjusted R^2 = .07, F (3, 242) = 7.16***]				
Disclosure	-0.17	0.06	-.17	-2.81**
Age	-0.01	0.01	-.14	-2.21 *
Income	-0.05	0.02	-.13	-1.97
Step 2 [ΔR^2 = .16, adjusted R^2 = .23, ΔF(2, 240) = 25.80***]				
Disclosure	0.03	0.07	.03	0.39
Age	-0.01	0.00	-.09	-1.60
Income	-0.04	0.02	-.09	-1.60
Internalised Homophobia	0.21	0.06	.25	3.51**
Sense of Belonging–Gay Friendships	-0.30	0.06	-.30	-4.88***
Step 3 [ΔR^2 = .00, adjusted R^2 = .23, ΔF(1, 239) = 0.08]				
Disclosure	0.03	0.07	.03	0.42
Age	-0.01	0.00	-.10	-1.61
Income	-0.04	0.02	-.09	-1.61
Internalised Homophobia	0.21	0.06	.25	3.48**
Sense of Belonging–Gay Friendships	-0.30	0.06	-.30	-4.85***
Internalised Homophobia x Sense of Belonging– Gay Friendships	0.02	0.05	-.02	-0.29

*p < .05. **p < .01. ***p < .001.

The variance in depressive symptoms scores explained by demographic variables was 7%. Internalised Homophobia and Sense of Belonging to Gay Friends explained an additional 16% of variance in depressive symptoms scores at Step 2. Both Internalised Homophobia and Sense of Belonging to Gay Friends were shown to predict depressive symptoms significantly in Step 2. As indicated by these results, there is support for the compensatory model. The results do not provide support for the Risk-Protective Model, as the addition of the interaction term in Step 3 did not explain any more variance in depressive symptoms. The final model accounted for 23% of the variance in depressive symptoms scores, $F(6, 239) = 12.88$, $p < .001$. In the final model, lower levels of depressive symptoms were associated with lower levels of internalised homophobia and higher levels of sense of belonging to gay friends.

The results for testing of the Protective-Protective Model, when controlling for disclosure, age and income, are presented in Table 10. The amount of variance in depressive symptoms scores explained by the demographic variables was 7%. The addition of internalised homophobia, the number of protective factors and the interactions terms in step 2 increased the amount of explained variance in depressive symptoms scores by 24%, $F(8, 237) = 14.13$, $p < .001$. Although, both internalised homophobia, the number of protective factors were significant predictors of depressive symptoms scores, the interaction term for these two variables was not a significant predictor of depressive symptoms scores. Therefore, these results indicate that there is no support for the Protective-Protective Model. The final model indicates that when exposed to the same level of internalised homophobia, individuals with more protective factors

do not experience less depressive symptoms than those with less protective factors.

Table 10

Results of the Analysis for Testing the Protective-Protective Model, when Controlling for Disclosure, Age and Income (N = 246)

	b	*SE*	*β*	*t*
Step 1 [R^2 = .08, adjusted R^2 = .07, F (3, 242) = 7.16***]				
Disclosure	-0.17	0.06	-.17	-2.81**
Age	-0.01	0.01	-.14	-2.21 *
Income	-0.05	0.02	-.13	-1.97
Step 2 [ΔR^2 = .24, adjusted R^2 = .30, ΔF(5, 237) = 16.91***]				
Disclosure	0.08	0.07	.08	1.20
Age	-0.01	0.00	-.08	-1.33
Income	-0.03	0.02	-.07	-1.18
Internalised Homophobia	0.17	0.06	.20	2.74**
Number (#) of protective factors	-0.26	0.05	-.43	-5.45***
Internalised Homophobia x # of protective factors	0.01	0.04	.02	0.29
Internalised Homophobia x Internalised Homophobia	0.05	0.05	.06	0.92
Internalised Homophobia x Internalised Homophobia x # of protective factors	0.00	0.03	-.00	-0.03

*p < .05. **p < .01. ***p < .001.

3.4 Aim 3 Hypothesis Testing

The correlation and covariance matrices for the variables of interest are shown in Tables 11 and 12, respectively.

Table 11

Correlation Matrix for Model Predicting Depressive symptoms (*N* = 246)

Variable	1	2	3	4	5	6
1.Depressive symptoms	-	37***	-.55***	-.48***	-.32***	-.41***
2. Internalised Homophobia		-	-.47***	-.44***	-.22**	-.39***
3.SB–General Community			-	.62***	.42***	.45***
4.SB–Gay Community				-	.66***	.62***
5.SB–Gay Organisations					-	.55***
6.SB–Gay Friends						-

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 12

Co-variance Matrix for Model Predicting Depressive symptoms (*N* = 246)

Variable	1	2	3	4	5	6
1.Depressive symptoms	-	22.50	-11.61	-19.20	-20.07	-28.53
2. Internalised Homophobia		-	-13.94	-54.57	-63.85	-60.72
3.SB–General Community			-	16.34	21.26	33.87
4.SB–Gay Community				-	63.28	55.06
5.SB–Gay Organisations					-	67.90
6.SB–Gay Friends						-

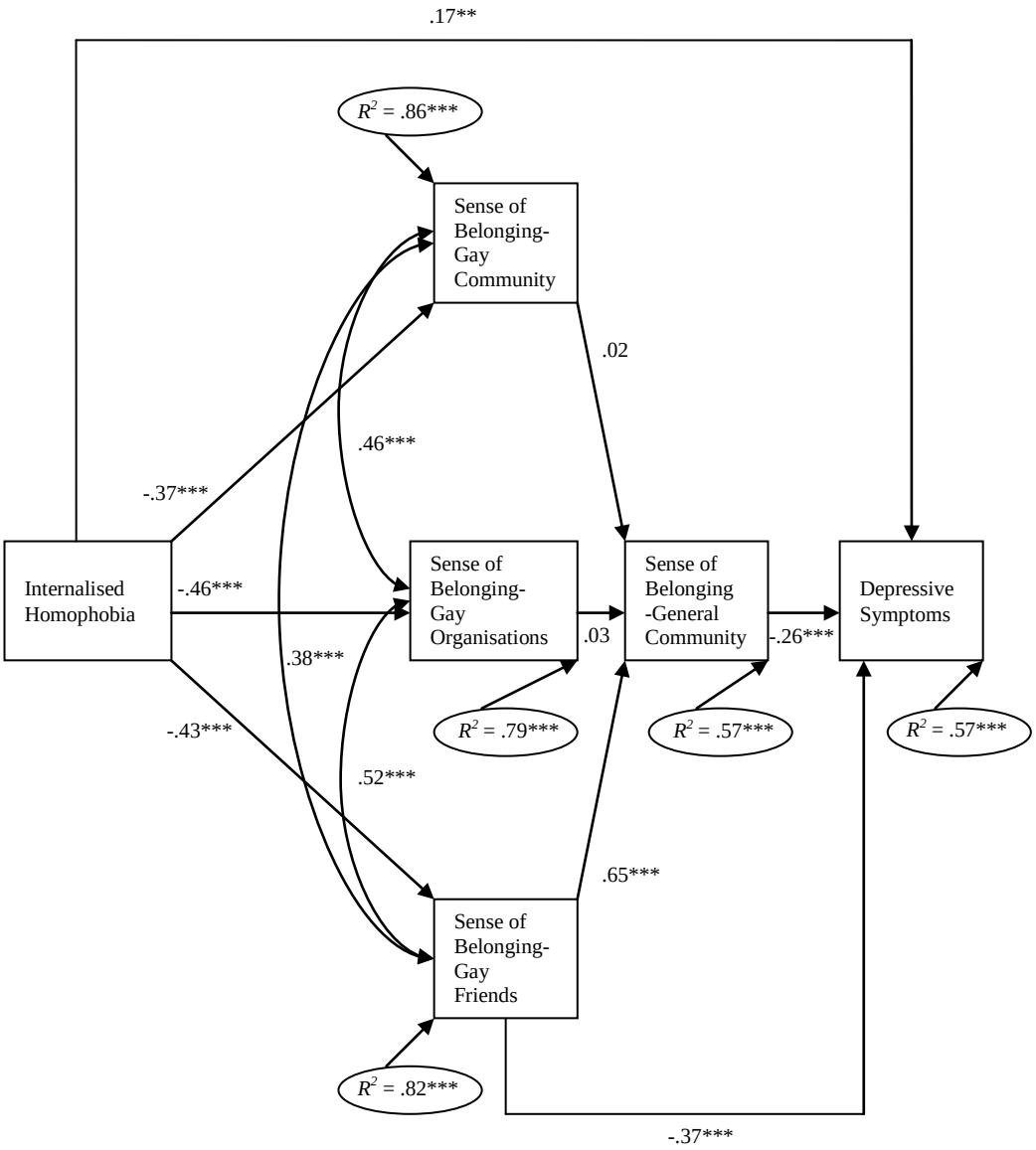
*$p < .05$. **$p < .01$. ***$p < .001$.

Examination of the fit indices for the hypothesised model indicate that model fitted the data poorly; χ^2 (4) = 33.13, $p < .001$, CFI = 0.95, TLI = 0.81, SRMR = 0.05, RMSEA = 0.17, RMSEA 90% CI = 0.12-0.23. Only the SRMR indicates that the model is a good fit, all other fit indices indicated that this model does not adequately predict depressive symptoms in gay men. M-Plus provides a

model modification index that provides information on how a poorly fitting model can be improved. The modification index is a calculation of how much χ^2 for the model would be reduced if a path between two variables was added to the model, with larger values suggesting a greater improvement in fit for the model (Kline, 2005). The model modification index for the hypothesised model indicated that the model would be improved by adding a direct path from sense of belonging to gay friends to depressive symptoms. As the adding of this path was consistent with the evidence provided by the results of other studies (e.g., Woolwine, 2000) it was decided to modify the model in this way.

The revised model is shown in Figure 2. The fit indices for the revised model, shown in Figure 2, were χ^2 (3) = 6.68, $p > .05$, CFI = 0.99, TLI = 0.97, SRMR = 0.02, RMSEA = 0.07, RMSEA 90% CI = 0.00-0.14. All the fit indices except the RMSEA indicate that the revised model is a good fit for the data. Kline (2005) argued, however, that if the range of the RMSEA 90% CI included .05 then a RMSEA above the cut off may be due to sampling error. In these circumstances, Kline recommended not interpreting the RMSEA as indicating poor fit, but advised that it still does not indicate good fit. The sample size of the collected data may be too small to give a clear outcome on the RMSEA (Kline, 2005). Curran et al. (2003) argued that samples, like the current study, larger than 200 participants, are unlikely to affect the RMSEA. Others, however, such as Hu and Bentler (1998, 1999) argue that sample size increases error in the calculation of all fit indices whenever a sample, like the current study, have less than 250 participants. Given that there is some support for the size of the current sample adversely affecting the RMSEA, it was decided not to base the decision about fit on this index. As all other fit indices indicated that the model was a

good fit for the data, it was decided that model adequately predicted depressive symptoms in gay men.



*p < .05. **p < .01. ***p < .001.

Figure 2. Revised path model predicting depressive symptoms.

Path analysis allows for the testing of both direct and indirect relationships between variables of interest. The direct relationship between variables is indicated in the model by straight arrows between these variables.

As shown in Figure 2, there are a number of significant direct and indirect relationships. All the paths between internalised homophobia and depressive symptoms via sense of belonging gay friends and sense of belonging general community are significant. This indicates that internalised homophobia has two indirect relationships with depressive symptoms, one that exists via both sense of belonging gay friends and sense of belonging general community and the second via sense of belonging gay friends. Additionally, the path between internalised homophobia and depressive symptoms is also significant, indicating a direct relationship between these variables. However, as shown in Figure 2, not all of the paths are significant. The path between sense of belonging gay community and sense of belonging general community are non-significant. Another non-significant path was that between sense of belonging gay organisations and sense of belonging general community. Therefore, neither sense of belonging to gay community or gay organisations predicts sense of belonging to the general community.

The impact of all variables between internalised homophobia and depressive symptoms can be explored via M-Plus. Figure 2 demonstrates that internalised homophobia has an indirect effect on depressive symptoms via both sense of belonging to gay friends and sense of belonging to the general community, r (244) = .07, $p < .001$. Additionally, Figure 2 shows that internalised homophobia indirectly influences depressive symptoms via sense of belonging to gay friends, r (244) = .16, $p < .001$. These results indicate partial mediation effects, as the direct relationship between internalised homophobia and depressive symptoms remains significant despite the presence of two significant indirect relationships between these two variables.

3.4.1. Summary of Aim 3 Hypothesis Testing Results

The results of the path analysis indicate that higher levels of internalised homophobia predict higher levels of depressive symptoms, and that the influence of internalised homophobia on depressive symptoms is partially mediated by a direct relationship between sense of belonging to gay friends and sense of belonging to the general community. Additionally, sense of belonging to gay friends mediates the relationship between internalised homophobia and depressive symptoms, independently of sense belonging to the general community, by directly predicting lower levels of depressive symptoms. Internalised homophobia directly influences sense of belonging to the gay community and to gay organisations. Neither of these variables, however, have an influence on depressive symptoms, via sense of belonging to the general community.

3.5. Summary of Results

The results indicate that internalised homophobia is a risk factor for depressive symptoms among gay men. These results also suggest that sense of belonging to the general community, gay community, gay organisations and gay friends are protective factors for depressive symptoms among gay men. There was support for the compensatory model for each protective factor, but no support for the risk-protective and protective-protective models. Finally, there was evidence that both sense of belonging to gay friends and to the general community partially mediated the relationship between internalised homophobia and depressive symptoms. Additionally, this partial mediation effect also occurred via sense of belonging to gay friends.

Chapter 4: Discussion

4.1. Overview of the Aims of the Present Study

This study investigated how internalised homophobia and sense of belonging influence depressive symptoms among gay men. The first aim of this study was to verify that internalised homophobia was a risk factor for depressive symptoms among gay men and that sense of belonging to the general community, gay community, gay organisations and gay friends were protective factors for depressive symptoms among gay men. In order to understand how these proposed risk and protective factors interacted to influence depressive symptoms the second aim of this study was to test the effectiveness of various resilience models in explaining these relationships. An alternative model to these resilience models that may explain the relationships is mediation. Therefore, the third aim of this study was to determine if there were any mediation effects present, by exploring both direct and indirect relationships between internalised homophobia and depressive symptoms. Sense of belonging to the general community, the gay community, gay organisations and gay friendships were expected to mediate the relationship between these two variables.

4.2. Aim 1

4.2.1. Hypothesis 1

There was support for the hypothesis that internalised homophobia would have a direct negative relationship with depressive symptoms. The results of this study indicated that higher levels of internalised homophobia were associated with higher levels of depressive symptoms among gay men. This association between these two variables confirms that internalised homophobia is a risk factor for depressive symptoms among Australian gay men. This result is to be

expected, as internalised homophobia is an indication that a gay man has internalised society's negative perception of homosexuality, so that they are not comfortable with their own sexuality or that of other gay men (Balsam & Mohr, 2007; Igartua et al., 2003; Meyer, 1995; Ratti et al., 2000; Shidlo, 1994; Williamson, 2000). Internalised homophobia, therefore, is a stressor that develops in gay men brought up in a heterosexist Western society (Igartua et al., 2003).

The direct relationship between internalised homophobia and depressive symptoms found in the current study is consistent with the findings of most studies (Frost & Meyer, 2009; Gold et al., 2007; Igartua et al., 2003; Newcomb & Mustanski, 2010; Wagner et al., 1996). Two US studies (Lewis et al., 2003; Span & Derby, 2009) have failed to find a relationship between internalised homophobia and depression in gay men, lesbians and bisexuals. However, both of these studies used samples that had very low levels of internalised homophobia. Therefore, it is possible that a restricted range of variance prevented them from finding this association. Higher levels of internalised homophobia have previously been found to be associated with higher levels of depression in samples of gay men, lesbians and bisexuals, in both the US (Frost & Meyer, 2009; Gold et al., 2007) and Canada (Igartua et al., 2003). Similar results have been found in a US sample of HIV+ gay men (Wagner et al., 1996). Additionally, a recent meta-analysis study found a small to moderate relationship between internalised homophobia and depression among gay men, lesbians and bisexuals (Newcomb & Mustanski, 2010).

It is possible to consider internalised homophobia as being a specific measure of worthlessness and low self-esteem that is relevant for this population

(Igartua et al., 2003). Research indicates that higher levels of internalised homophobia are associated with lower levels of self-esteem in gay men and men who have sex with men (Allen & Olsen, 1999; Rowen & Malcolm, 2002). Self-esteem mediated the relationship between internalised homophobia and depression among US gay men, lesbians and bisexuals (Herek et al., 2009). Similarly, Szymanski and Carr (2008) found that self-esteem mediated the relationship between internalised homophobia and psychological distress, among US gay men. Additionally, an association between higher levels of internalised homophobia and higher levels of internalised shame was found among gay men (Allen & Olsen, 1999). Rowen and Malcolm found that there was an association between high levels of guilt about sexual activity and higher levels of internalised homophobia in men who have sex with men. An association between poorer self-concept and higher levels of internalised homophobia was found in both men who have sex with men and gay men (Allen, 2002; Rowen & Malcolm, 2002). Finally, gay men who tend to internalise problems, are significantly higher in internalised homophobia than those that externalise problems (Allen, 2002).

4.2.2. Hypothesis 2

There was support for the hypothesis that sense of belonging to the general community, gay community, gay organisations and gay friends would all have a direct positive relationship with depressive symptoms. The results of this study provided further evidence that sense of belonging is a protective factor for depressive symptoms among adults. Similar results have been found by research using various population samples of adults in both Australia and the US (Bailey & McLaren, 2005; Cheonarom et al., 2005; Hagerty et al., 1996; McLaren et al.,

2001; McLaren & Challis, 2009). Although commentators have argued that sense of belonging is important in the mental health of gay men (Johnson & Johnson, 2001), only recently a small number of studies on sense of belonging have used samples of gay men (McLaren, Jude et al., 2007, 2008). The results of the present research provided further evidence that sense of belonging is a protective factor for depressive symptoms in gay men. This result has been found previously in two Australian studies of sense of belonging among gay men (McLaren, Jude et al., 2007, 2008).

A major limitation of the research that the current study attempted to over come, is that most of studies focused on sense of belonging in general. In their recent studies, McLaren, Jude et al. (2007, 2008) have explored sense of belonging to the general community and gay community in gay men. Like the present study they found a negative association between sense of belonging to the general community and depressive symptoms among gay men (McLaren, Jude et al., 2007, 2008) and sense of belonging to the gay community and depressive symptoms (McLaren et al., 2008). However, unlike the present study they did not explore how depressive symptoms were influenced by sense of belonging to gay organisations and gay friends. Another recent Australian study, McCallum and McLaren (2011) investigated sense of belonging to the general community and sense of belonging to a support group for sexual minority youth. These researchers found that both of these spheres of sense of belonging were protective factors for depressive symptoms among gay, lesbian and bisexual adolescents. Similarly, the present study found that sense of belonging to gay organisations was a protective factor for depressive symptoms among Australian

gay men. Additionally, the present study found that sense of belonging to gay friends was also a protective factor for these gay men.

Researchers have argued that higher levels of sense of belonging to the general community or gay community are likely to be associated with acceptance and support experienced by gay men, resulting in less depressive symptoms (McLaren et al., 2008). This assertion probably also applies to sense of belonging to gay organisations and gay friends. Woolwine (2000) argued that gay men do not identify as strongly to the broad concept of gay community as they do with gay organisations and gay friends. US gay men living in rural areas overcame their initial experience of social isolation when coming out, by developing a network of gay friends (Cody & Welch, 1997). Frable et al. (1997) found that sense of belonging to gay organisations and friends improves the self-identity of gay men and the acceptance of their sexuality. Additionally, they found an association between positive gay identity and both being openly gay and being involved in social networks of gay men. When faced with prejudice and discrimination gay men often turn towards each other for support (Frable et al., 1997; Woolwine, 2000).

4.3. Aim 2

The second aim of this study was to test the application of resilience models in explaining the relationships between internalised homophobia, several spheres of sense of belonging and depressive symptoms among gay men. It appears that this is the first study to explore resilience models with this population or variables.

4.3.1. Hypothesis 1

There was support for the hypothesis based on the compensatory model. As predicted, the direct influence of internalised homophobia on depressive symptoms was compensated for by the direct influence of sense of belonging to the general community, gay community, gay organisations and gay friends. The support for the compensatory model indicates that the direct influence of sense of belonging to the general community, gay community, gay organisations and gay friends on depressive symptoms offsets the direct influence of internalised homophobia. This result is to be expected given the direct effects of internalised homophobia and sense of belonging on depression found in this study and in other studies (e.g., Frost & Meyer, 2009; McLaren, Jude et al., 2007). Less developed gay identity has been associated with higher levels of internalised homophobia (Rowen & Malcolm, 2002). In contrast, positive gay identity has been found to be associated with socialising with and forming friendships with other gay men (Frable et al., 1997). It possible, therefore, that this compensatory effect occurs due to the presence of sense of belonging off-setting the negative influence that internalised homophobia has on a gay man's perception of self. Moreover, being accepted and supported by one segment of society may help a gay man cope with the rejection of another segment of society.

4.3.2 Hypothesis 2

There was no support for the hypothesis informed by the risk-protective model. The results of this study do not indicate that sense of belonging to the general community, gay community, gay organisations and gay friends reduces the influence of internalised homophobia on depressive symptoms. The lack of support for this model indicates that sense of belonging to the general

community, gay community, gay organisations and gay friends, do not interact with internalised homophobia to influence depressive symptoms.

4.3.3 Hypothesis 3

The results of this study also did not support the hypothesis based on the protective-protective model. There is no indication that an increasing number of protective factors weakened the relationship between internalised homophobia and depressive symptoms. The lack of support for this model indicates that depressive symptoms are not influenced by an interaction between internalised homophobia and the number of protective factors. The lack of interaction between internalised homophobia and the number of protective factors suggest that the number of protective factors a gay man has does not reduce the effects of internalised homophobia on depressive symptoms. The lack of support for this model is not surprising considering that none of the spheres of sense of belonging investigated moderated the relationship between internalised homophobia and depressive symptoms.

4.4 Aim 3 and Hypothesis

There was partial support for the proposed path model. As hypothesised, there was a direct relationship between internalised homophobia and depressive symptoms. In addition, as hypothesised, internalised homophobia directly influenced sense of belonging to the gay community, gay organisations and gay friendships. Only sense of belonging to gay friends, however, directly influenced sense of belonging to the general community. Sense of belonging to the gay community and gay organisations did not have a direct relationship with sense of belonging to the general community. Consistent with the hypothesis there was a direct relationship between sense of belonging to the general community and

depressive symptoms. These results indicate that the relationship between internalised homophobia and depressive symptoms is partially mediated by a direct relationship between sense of belonging to gay friends and sense of belonging to the general community. An unexpected result was that sense of belonging to gay friends directly influenced depressive symptoms, in addition to its indirect influence on depressive symptoms. This result indicates that sense of belonging to gay friends also partially mediates the relationship between internalised homophobia and depressive symptoms, independently of sense of belonging to the general community.

As far as can be determined, no other study has investigated if sense of belonging mediated the relationship between internalised homophobia and depressive symptoms. A relationship between internalised homophobia and both sense of belonging and a sense of social acceptance, however, has been found in other studies (Cox et al., 2011; Herek et al., 2009; Preston et al., 2007; Ratti et al., 2000; Ross & Rosser, 1996). Items on an internalised homophobia scale that reflected a concern about being publicly identified as gay and a lack of comfort socialising with gay men were associated with items that reflected being less out and not participating in gay groups (Ross & Rosser, 1996). Preston et al. found an association between the experience of internalised homophobia and living in a community or a family that was intolerant of gay men. Among Canadian men, those with less acculturation to the gay or general communities tended to have higher levels of internalised homophobia (Ratti et al., 2000). Similarly, US gay men, lesbians and bisexuals, who had higher levels of internalised homophobia, were less positive about belonging to a sexual minority community (Herek et al., 2009). Finally, gay men, lesbians and bisexuals, in the US, experienced less

internalised homophobia when their environment accepted their sexuality and they had stronger connections with a sexual minority community (Cox et al., 2011).

McLaren et al. (2008), unlike the present study, found a direct relationship between sense of belonging to the gay community and sense of belonging to the general community. Additionally, unlike the present study, they found an indirect relationship between sense of belonging to the gay community and depressive symptoms via sense of belonging to the general community. In their study, however, McLaren et al. (2008) defined gay community as viewing gay men collectively. They did not differentiate between different forms of gay community, as suggested by Woolwine (2000). The results of the present study are consistent with Woolwine's conclusion about emotional attachment and the definition of community. Woolwine argued that a gay man would have a stronger emotional attachment to a community that they define by their actual personal experiences rather than the actual or perceived group experiences.

The result of sense of belonging to gay friends being more protective than other forms of sense of belonging among gay men is also consistent with other studies (e.g., Chapple et al., 1998). Gay men who feel that they are different to the men that make up the gay community do not feel part of it (Chapple et al., 1998; Fraser, 2008; LeBeau & Jellison, 2009). How positively Australian gay men perceived the gay community, depended on how important their sexuality was to their self-identity (Fraser, 2008). Australian working class gay men who felt that they did not fit in with the gay scene that was usually defined as the gay community created their own gay community defined by their friendship network (Chapple et al., 1998). Similarly, US and UK studies of gay men found that gay

men developed supportive friendship networks, consisting predominately of other gay men (Cody & Welch, 1997; Hart & Fitzpatrick, 1990). Fraser (2008) argued that due to the increasing acceptance of gay men in mainstream society there are more opportunities for these men to socialise outside the gay community. Moreover, although the "gay scene" can positively influence the development of a positive self-identity, it can lead to men feeling more self-conscious (Ridge et al., 2006). For example, gay men in this scene can become more self-conscious about how they look due to the greater focus on the male body in this scene (Ridge et al., 2006). Overall, results of the mediation model highlight the role of sense of belonging to gay friends, as opposed to the global gay community or gay organisations. This result has clear implications for clinical practice.

4.5 *Limitations*

A number of limitations need to be kept in mind when considering the results of this study. First, the study was cross-sectional in design. Due to this design, the patterns observed in the data may not be consistent over time and it is not possible to determine causality. A cross sectional design also does not over come the problem of common method variance, which is variance that occurs due to the method used to measure the construct rather than the construct itself (Podskaffe, McKenzie, Lee, & Podsakoff, 2003). Method variance commonly occurs when both the outcome and predictor variables are gathered from the same source in the same circumstances (Podskaffe et al., 2003).

Another limitation of this study was that all the participants were self-identified gay men. An Australian population survey found that only 1.6% of an adult community sample identified as gay, but 8.6% of men reported a history of

being sexually attracted to another man or having sex with another man (Smith, Rissel, Richters, Grulich, & de Visser, 2003). It is known that internalised homophobia does not just affect gay men, but also bisexual men and men who have sex with other men and do not identify as being gay (Balsam & Mohr, 2007; Igartua et al., 2003; Meyer, 1995; Ratti et al., 2000; Shidlo, 1994; Williamson, 2000). Therefore, it is not possible to determine if these results apply to men who have sex with other men, but do not identify themselves as being gay, or men who identify as bisexual. It is possible that internalised homophobia will affect these men differently.

Additionally, it would be expected that men who do not identify as gay would not have a strong sense of belonging to gay community, gay organisations or gay friends. Items that best measure the construct of internalised homophobia are those that reflect a lack of comfort in being identified as gay and socialising with gay men (Ross & Rosser, 1996). Further, not being comfortable with being identified as or socialising with gay men, is associated with not participating in the gay groups (Ross & Rosser, 1996). This also has implications for the sampling method used that involved distributing questionnaires at gay festivals, as men who do not want to be publicly identified as being gay would probably not fill in such a questionnaire in public and would be less likely to attend a gay festival. It is, therefore, likely that the level of internalised homophobia found in the present sample of self-identified gay men attending a gay community event is restricted. Additionally, by using a sample of self-identified gay men attending a gay community event it is possible that the levels of sense of belonging to the various spheres of community are enhanced. It is likely, however, that the method of recruitment did not affect the outcome of this study. Hagerty et al.

(1993) in their theory of Human Relatedness describe sense of belonging as a stable psychological state that is not overly influenced by external factors.

Not wanting to be publicly identified as gay and being uncomfortable with socialising with other gay men has been associated with being less open about homosexuality (Ross & Rosser, 1996). Most of the participants reported that 75% or more of their acquaintances knew of their sexuality. Therefore, if more "closeted" gay men were included in this study the results may have been different. Additionally, due to the convenience sampling used in this study, the proportion of openly gay men in this study may not be the equivalent of the proportion of openly gay men living in the community. It is possible, therefore, that this sample of gay men is not representative of the population.

There are also limitations in how sense of belonging to the general community, gay community, gay organisations and gay friends were measured for this study. The measure of sense of belonging to gay organisations and friends was a two item VAS, which has unknown psychometric properties. Although correlations between these VAS measures and the two versions of the sense of belonging inventory-psychological subscale used in this study indicate that that these VAS measures were good estimates of sense of belonging to these communities, measures with better psychometric qualities may have improved accuracy and increased confidence in the results presented.

Similarly, the sense of belonging inventory-psychological subscale was modified for this study so that it could measure sense of belonging to both the general and gay communities. Despite this subscale in its original form having strong psychometric qualities the alterations to the wording of the items means that it cannot be assumed that the new versions have the same strong

psychometric qualities. Although the Cronbach's alpha for these versions of the sense of belonging inventory-psychological subscale were high, it is possible that these modifications affected the validity of this measure in some way. Additionally, there was substantial overlap between these two measures, as indicated by there being a strong positive correlation between the two. It would have been preferable to use measures specifically designed to measure sense of belonging to the general community, gay community, gay organisations and gay friends. However, such measures currently do not exist.

4.6. Recommendations for Future Research

The limitations of the present study provide the basis for future research using psychometric measures specifically developed to measure sense of belonging to different types of communities and a longitudinal design. There is also a need to replicate results in a sample of more "closeted" gay men and men who have sex with men, but do not identify as being gay or men who identify as bisexual. Given the results of the current research indicated the importance sense of belonging to gay friendship networks to the mental health of gay men, further investigation of friendship networks is required. Other studies have identified the importance of acceptance of the gay man's sexuality from his environment (Cox et al., 2011) and that non-gay friends can also provide support to gay men (Cody & Welch, 1997). There is a need for future studies to consider sense of belonging to non-gay friends to determine if this sense of belonging is as important as sense of belonging to gay friends for the mental health of gay men. A random control study would allow for testing the efficacy of a sense of belonging intervention for gay men. A study such as this could determine if an intervention designed to increase the sense of belonging of gay men, especially

to gay friends, actually reduces the experience of internalised homophobia and depressive symptoms.

4.7. Implications

As internalised homophobia results from the internalisation of society's negative perception of homosexuality (Balsam & Mohr, 2007; Igartua et al., 2003; Meyer, 1995; Ratti et al., 2000; Shidlo, 1994; Williamson, 2000), there is a need to increase tolerance within society towards gay men (Mason, 1993; Mouzos & Thompson, 2000). There is a particular need to continue increasing the level of acceptance of gay men in Western culture and society (Burn et al., 2005; Fraser, 2008) and create an environment where gay men can be open about their sexuality without fear of discrimination (Burn et al., 2005). The main way to achieve this is to abolish the notion that heterosexuality is superior to homosexuality (Mason, 1993). This would require changes to social norms, as well as changes in the way that homosexuality is discussed in political and religious discourse (Mason, 1993). New social norms need to be created that discourage hostility towards gay men through promoting heterosexual role models who have a non-hostile attitude towards gay men (Herek, 1986).

Intolerance towards gay men could be addressed through changing government policy (McLaren, Jude et al., 2007), education programs in schools (Mason, 1993; McLaren, Jude et al., 2007; Mouzos & Thompson, 2000), law reform and media coverage of the impact of intolerance towards gay men (Mason, 1993). Education programs in schools and universities could be used to teach students tolerance and respect towards gay men (Jayakumar, 2009; Mouzos & Thompson, 2000). Men who have deeply ingrained with homophobic attitudes could be treated through group interventions that challenge their

attitudes by promoting concepts such as justice, fairness and open mindedness (Herek, 1986). Among Canadian university students, a workshop was an effective way to reduce homophobic attitudes (Rye & Meany, 2009). Additionally, universities could create policies that ensure that there is a tolerant culture towards gay students and staff members (Jayakumar, 2009).

Due to the prevalence of heterosexism in society, heterosexual therapists need to be aware of how their own hererosexism could affect the way that they interact and perceive gay clients (Bowers, Plummer, & Minichiello, 2005; Davies, 2006; Garnets et al., 1990; McGeorge & Clarkson, 2011; Kashubeck-West, Szymanski, & Meyer, 2008; Pachankis & Goldfried, 2004; Twist, Murphy, Green, & Palmanteer, 2006). For example, therapists need to avoid assuming everyone is heterosexual and be aware of issues that are unique to gay men, such as gay identity formation (Pachankis & Goldfried, 2004). There is also a need for therapists to receive training and supervision in treating gay men not only during postgraduate training but also during their careers (Brown, 2004; Davies, 2006; Kissinger, 2009; Mitchell, 2010). It is important that supervisors challenge any heterosexist attitudes that they detect in their supervisees (Kashubeck-West et al., 2008). Training programs can help educate supervisors and students about biases against sexual minorities and issues confronting gay men (Bowerset al., 2005; Mair, 2003; Smith, Foley, & Chaney, 2008; Twist et al., 2006). Training programs could also focus on wider issues such as how institutions and institutional policies promote and maintain heterosexism and how these contribute to the development of internalised homophobia (Kashubeck-West et al., 2008).

To facilitate a gay client resolving their internalised homophobia, therapists need to create a therapeutic environment that leads to the gay men feeling that their sexuality is accepted by the therapist (Bowers et al., 2005; Brown, 2004; Cooper, 2008; Haldeman, 2002; Mair, 2003; McGeorge & Clarkson, 2011; Pachankis & Goldfried, 2004). Due to the unique issues that gay clients bring to therapy sessions, it is necessary for therapists to adopt an approach that is different to how they would treat heterosexual clients (Pachankis & Goldfried, 2004). Gay affirmative therapy is considered the best approach to providing psychological treatment to gay clients (Pachankis & Goldfried, 2004). The aim of gay affirmative therapy is to affirm and facilitate the development of the client's gay identity and enhance their experiences (Pachankis & Goldfried, 2004). Psychologists need to convey to their gay clients that a gay identity develops from a natural variation in human sexuality and that the adoption of a gay identity is not indicative of a mental disorder (Cooper, 2008; Haldeman, 2002).

Therapists need to be aware of what gay identity means to the client and not make any assumptions about this (Brown, 2004). Therapists need to avoid the use of hetero-normative language and use alternative terms on forms and during sessions, such as using the term partner instead of spouse (McGeorge & Clarkson, 2011). There is a need for therapists to have familiarity with the gay culture, including terms such as "cottaging" (Mair, 2003). Other strategies that facilitate therapists reducing the influence of heterosexism on sessions are being wary of stereotypes and assumptions, seeking the unique perspective of the client and admitting when ignorant of an issue (Bowers et al., 2005). Therapists could also place reading material about gay men in their waiting room and display the

rainbow symbol to create a gay affirmative environment (McGeorge & Clarkson, 2011).

There is a need for to be aware of how internalised homophobia is related to mental health in gay men and be aware of how stress related to their sexual minority status may exacerbate other issues that they present in therapy (McGeorge & Clarkson, 2011). The results of this study provide further evidence of the direct involvement of internalised homophobia in the development of depressive symptoms among gay men. This result suggests that there is a need to screen gay men for inflated levels of internalised homophobia when treating them for depression (Igartua et al., 2003). If a gay client is found to have high levels of internalised homophobia, this can then be addressed during their treatment for depression (Igartua et al., 2003). For example, if treating depression with cognitive therapy, the therapist can treat internalised homophobia as a faulty cognition that results from maladaptive assumptions (Igartua et al., 2003). These assumptions can then be identified and challenged through reality testing and alternative ways of thinking (Igartua et al., 2003).

Therapists need to assist clients struggling with internalised homophobia to recognise the negative effect of heterosexism on their life (Kashubeck-West, Szymanski, & Meyer, 2008; McGeorge & Clarkson, 2011). When a client in the earlier stages of gay identity development, it is useful for the therapist to acknowledge that their internalised homophobia is an understandable reaction to societal attitudes towards their sexual identity (Pachankis & Goldfried, 2004). Therapists working with clients in earlier stages of gay identity need to facilitate the client's development of skills to manage their feelings of stress, anxiety, shame and guilt (Cooper, 2008). Therapists can teach their clients struggling

with internalised homophobia a variety of strategies to cope with heterosexism (Kashubeck-West et al., 2008). These strategies might include relaxation training, talking to supportive friends and exercise (Kashubeck-West et al., 2008). Therapists can engage the client in assessing the suitability and effectiveness of different strategies as well as helping the client learn and practice new skills to implement these strategies (Kashubeck-West et al., 2008). The therapist could provide the client with reading material and contact numbers in order to increase the client's knowledge of being gay and community supports that exist (Cooper, 2008). The therapist can also encourage the client to assess the level of support in environments before deciding wether or not to enter these environments (Kashubeck-West et al., 2008).

The results of the present study also provide evidence that the presence of internalised homophobia can increase the likelihood of a gay man developing depressive symptoms, by reducing their sense of belonging. This appears to be the first study to investigate how sense of belonging affects the relationship between internalised homophobia and depressive symptoms. These results suggest that interventions aimed at improving the mental health of gay men through developing sense of belonging, need to address issues around internalised homophobia.

The present study demonstrated that sense of belonging to the general community and to gay friends are important protective factors for depressive symptoms among gay men. This finding suggests that the assessment of sense of belonging to both the general community and gay friends among depressed gay men is required as a part of their treatment for depressive symptoms. The results also indicate that it is necessary to address low levels of these spheres of sense of

belonging, when treating gay men for depressive symptoms. These results also suggest that encouraging depressed gay men to join support groups (Johnson & Johnson, 2001) or providing group therapy for gay men may be beneficial in treating depressive symptoms, as they would be positioned to receive support and acceptance from similar others. These results, as with other research (Frable et al., 1997; Woolwine, 2000), also suggest that encouraging gay men to socialise with other gay men is a way of promoting mental health and a positive self-identity. Therapists can encourage involvement in gay organisations and patronage of gay friendly businesses (Kashubeck-West et al., 2008).

It is also necessary to identify any negative experiences that the client has in connecting with the wider gay community or gay organisations and explore the underlying reasons for these experiences (Riggle, Whitman, Olson, Rotosky, & Strong, 2008). The therapist could also facilitate the client identifying gay support or social groups that match their ideas, values and interests (Riggle et al., 2008). An important goal of therapy with this population is to facilitate the client developing supportive social networks (Riggle et al., 2008). Either interpersonal therapy or cognitive-behavioural therapy can be used to adjust the way that an individual views their social landscape (Steger & Kashdan, 2009). The therapist needs to encourage the client to look for opportunities for positive social interaction and there is a need to discuss any positive interaction in therapy so that the client learns to make the most of these interactions (Steger & Kashdan, 2009).

4.8. Conclusion

The results of this study provide an understanding of how internalised homophobia, sense of belonging and depressive symptoms are related. These

results provide further evidence that internalised homophobia is associated with increased levels of depressive symptoms. Based on the results sense of belonging to gay friends appears to influence the internalised homophobia-depressive symptoms relationship in two ways. Sense of belonging to gay friends appears to facilitate a gay man's sense of belonging to the general community and decrease the likelihood of a gay man experiencing a lowered mood.

Depression continues to be a significant mental health issue for Australian gay men. This disorder is not only relatively common but also contributes to a significant amount of functional impairment among Australian men. The results of the present study indicate that both internalised homophobia and sense of belonging play an important part in the occurrence of depressive symptoms among gay men. These results suggest that clinical interventions that reduce internalised homophobia and increase the sense of belonging to gay friends, as well as the general community, will reduce the amount of depressive symptoms experienced in this population. Creating a therapeutic environment that is accepting of gay clients and therapists being aware of issues related to being gay and working with gay clients, are essential in this work. Additionally, these results indicate that there is a need to promote tolerance towards gay men as a way of reducing the incidence of internalised homophobia and fostering sense of belonging among gay men. These results also indicate the need for further research with better designed measures and a more diverse sample of gay men.

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Appendix A

Plain Language Statement

"Sense of Belonging to Specific Communities and Mental Health"

Dear Potential Participant,

Thank you for your interest in this research being conducted by Kenneth Davidson, a Doctor of Psychology candidate, and Associate Professor Suzanne McLaren, at the University of Ballarat. This study will examine how sense of belonging and mental health varies among gay men and lesbians. The information that is being collected will be of value to health professionals seeking to assist gay men and lesbians.

If you volunteer to participate in this research, you will be asked to complete a questionnaire, which asks for some background information, your sense of belonging (e.g., I feel like an outsider in most situations) and your mental health (e.g., I felt sad). The attached questionnaire will take approximately 15 minutes to complete. It is very important that you answer each question as truthfully as possible for the research to be of significance.

You will also have the option of completing a brief questionnaire, assessing mood, three months after completing the whole questionnaire package. This is valuable, as it will allow us to assess how your feelings of belonging are related to your mental health in the long term and it is explained in detail on the last page of the questionnaire. *Please be assured that completing this initial questionnaire is of value, even if you do not want to do the follow up questionnaire in 3 months time.*

If you want to participate, please use the accompanying "reply paid" envelope to return the completed questionnaire to the researchers. Please note that returning the questionnaire is an indication that you understand the nature of the research and that you are freely volunteering to participate in the research. When your questionnaires are completed and returned, they will form a larger database from which only group data will be reported. Your individual results will not be reported and none of the information that you supply in this study will be able to be traced or linked back to you in any way.

You may withdraw your participation from this research at anytime during the completion of the questionnaire (particularly if you are experiencing distress). However, please understand that once you have returned the completed questionnaire, it will be impossible to identify your anonymous questionnaire among the larger pool and therefore withdrawal at this stage will not be an option. Questionnaires will be kept for a period of five years after any publications that arise from this study.

You are encouraged to discuss any questions that you may have during, or at the conclusion of the questionnaire, with the principal researcher Associate Professor Suzanne McLaren or your doctor. Should you prefer to discuss your issues anonymously, you may wish to contact Lifeline (available 24 hours a day: telephone 131 114 for the cost of a local call or free call 1300 651 251), or if relevant, the Gay and Lesbian Switchboard (telephone (03) 9663 2939 or free call 1800 184 527).

Please contact Associate Professor McLaren to obtain a copy of the results, which will be available at the end of 2009.

Thank you for considering participation in this research.

Assoc. Prof. Suzanne McLaren
Principal Researcher
(03) 5327 9628
E-mail: s.mclaren@ballarat.edu.au

Mr Kenneth Davidson
Student Researcher

Note: Should you (i.e. the participant) have any concerns about the conduct of this research project, please contact the Executive Officer, Human Research Ethics Committee, Research and Graduate Studies Office, University of Ballarat, PO Box 663, Mt Helen VIC 3353. Telephone: (03) 5327 9765.

Appendix B

Demographic Sheet

Thank you for volunteering to participate in this research.

Please read and complete the following questions regarding your background. Do not give your name or include any other specific personal information that could identify you.

1. What is your gender?
   - ❑ Male
   - ❑ Female
   - ❑ Intersex
   - ❑ Transgender
   - ❑ Other (please specify) _____

2. What do you consider your sexuality to be?
   - ❑ Gay Male
   - ❑ Lesbian
   - ❑ Bisexual
   - ❑ Queer
   - ❑ Don't know
   - ❑ Straight
   - ❑ Other (please specify) _____

3. What percentage of people that you know are aware of your sexual orientation?

❑ less than 25% ❑ 25% to 50% ❑ 51% to 75% ❑ more than 75%

4. What is your age? _____

5. Postcode of Residence _____

6. What is your relationship status?
   - ❑ Partnered (in a committed relationship)
   - ❑ Single
   - ❑ Married
   - ❑ Separated/Divorced
   - ❑ Widowed
   - ❑ Other (please state) _____

7. Highest Education Level Successfully Completed
   - ❑ Primary
   - ❑ Secondary School
   - ❑ TAFE/Trade Certificate
   - ❑ University – Undergraduate Degree
   - ❑ University – Postgraduate Degree
   - ❑ Other: _____

8. Current employment status

- ❑ Full time
- ❑ Part-time/casual
- ❑ Unemployed
- ❑ Retired
- ❑ Other: _____

9. Income (per annum)

- ❑ less than $10,000
- ❑ $10,000-$19,999
- ❑ $20,000-$29,999
- ❑ $30,000-$39,999
- ❑ $40,000-$49,999
- ❑ $50,000-$59,999
- ❑ $60,000-$69,999
- ❑ $70,000 +

Appendix C

Center for Epidemiological Studies–Depressive Scale

This scale consists of 20 statements. Please read each statement carefully, then tick the one answer for each statement which most applies to how often you felt over the past week:				
	Rarely or None of the time (less than 1 day)	Some or a Little of the time (1-2 days)	Occasionally or a Moderate amount of the time (3-4 days)	Most or All of the time (5-7 days)
1. I was bothered by things that don't usually bother me	❍	❍	❍	❍
2. I did not feel like eating; my appetite was poor	❍	❍	❍	❍
3. I felt that I could not shake off the blues even with help from my family	❍	❍	❍	❍
4. I felt that I was just as good as other people	❍	❍	❍	❍
5. I had trouble keeping my mind on what I was doing	❍	❍	❍	❍
6. I felt depressed	❍	❍	❍	❍
7. I felt that everything I did was an effort	❍	❍	❍	❍
8. I felt hopeful about the future	❍	❍	❍	❍
9. I thought my life had been a failure	❍	❍	❍	❍
10. I felt fearful	❍	❍	❍	❍
11. My sleep was restless	❍	❍	❍	❍
12. I was happy	❍	❍	❍	❍
13. I talked less than usual	❍	❍	❍	❍
14. I felt lonely	❍	❍	❍	❍
15. People were unfriendly	❍	❍	❍	❍
16. I enjoyed life	❍	❍	❍	❍
17. I had crying spells	❍	❍	❍	❍
18. I felt sad	❍	❍	❍	❍
19. I felt that people disliked me	❍	❍	❍	❍
20. I could not "get going"	❍	❍	❍	❍

Appendix D

Internalized Homophobia Scale

This scale consists of 20 statements that some gay men and lesbians think about themselves. Please read each statement carefully, then tick the one answer for each item which most applies to you:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Being gay/lesbian is a natural expression of sexuality in human beings	❍	❍	❍	❍	❍
2. I wish I were heterosexual	❍	❍	❍	❍	❍
3. When I am sexually attracted to someone of the same sex, I don't mind if someone else knows how I feel	❍	❍	❍	❍	❍
4. Most problems that gays/lesbians have comes from their status as an oppressed minority, not from their sexual orientation per se	❍	❍	❍	❍	❍
5. Life as a gay/lesbian is not as fulfilling as life as a heterosexual	❍	❍	❍	❍	❍
6. I am glad to be gay/lesbian	❍	❍	❍	❍	❍
7. Whenever I think a lot about being gay/lesbian, I feel critical about myself	❍	❍	❍	❍	❍
8. I am confident that my sexual orientation does not make me inferior	❍	❍	❍	❍	❍
9. Whenever I think a lot about being gay/lesbian, I feel depressed	❍	❍	❍	❍	❍
10. If it were possible, I would accept the possibility to be completely heterosexual	❍	❍	❍	❍	❍
11. I wish I could become more sexually attracted to the opposite sex	❍	❍	❍	❍	❍
12. If there were a pill that could change my sexual orientation, I would take it	❍	❍	❍	❍	❍
13. I would give up being gay/lesbian if I could	❍	❍	❍	❍	❍
14. Homosexuality is deviant	❍	❍	❍	❍	❍
15. It would not bother me if I had children who were gay/lesbian	❍	❍	❍	❍	❍
16. Being gay/lesbian is a satisfactory and acceptable way of life for me	❍	❍	❍	❍	❍
17. If I were heterosexual, I would probably be happier	❍	❍	❍	❍	❍
18. Most gay/lesbian people end up lonely and isolated	❍	❍	❍	❍	❍
19. For the most part, I do not care who knows I am gay/lesbian	❍	❍	❍	❍	❍
20. I have no regrets about being gay/lesbian	❍	❍	❍	❍	❍

Appendix E

Sense of Belonging Inventory-Psychological Subscale (General Community)

Think about the GENERAL (LARGELY HETEROSEXUAL) COMMUNITY. Please read each item carefully, then tick the one answer for each item which most applies to you when you think about the *General Community*				
	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I often wonder if there is any place in the General Community where I really fit in	❍	❍	❍	❍
2. I am just not sure if I fit in with my friends in the General Community	❍	❍	❍	❍
3. I would describe myself as a misfit at most social events in the General Community	❍	❍	❍	❍
4. I generally feel that people accept me in the General Community	❍	❍	❍	❍
5. Within the General community, I feel like a piece of a jigsaw puzzle that doesn't fit into the puzzle	❍	❍	❍	❍
6. I would like to make a difference within the General Community, but I don't feel that what I have to offer is valued	❍	❍	❍	❍
7. I feel like an outsider in the General Community	❍	❍	❍	❍
8. I am troubled by feeling like I have no place in the General Community	❍	❍	❍	❍
9. I could disappear for days and it wouldn't matter to others in the General Community	❍	❍	❍	❍
10. In general, I don't feel a part of the General Community	❍	❍	❍	❍
11. Within the General Community, I feel like I observe life rather than participate in it	❍	❍	❍	❍
12. If I died tomorrow, very few people from the General Community would come to my funeral	❍	❍	❍	❍
13. Within the General Community, I feel like a square peg trying to fit into a round hole	❍	❍	❍	❍
14. I don't feel that there is any place where I really fit in the General Community	❍	❍	❍	❍
15. I feel uncomfortable knowing that my background and experiences are so different from those who are in the General Community	❍	❍	❍	❍
16. I could not see or call my friends from the General Community for days and it wouldn't matter to them	❍	❍	❍	❍
17. I feel left out of things in the General Community	❍	❍	❍	❍
18. I am not valued by or important to people in the General Community	❍	❍	❍	❍

Appendix F

Sense of Belonging Inventory-Psychological Subscale (Gay Community)

If you identify as male, answer the questions in relation to the GAY COMMUNITY.

If you identify as female, answer the questions in relation to the LESBIAN COMMUNITY.

Please read each item carefully, then tick the one answer for each item which most applies to you when you think about the *Gay/Lesbian Community*

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I often wonder if there is any place in the Gay/Lesbian Community where I really fit in	❍	❍	❍	❍
2. I am just not sure if I fit in with my friends in the Gay/Lesbian Community	❍	❍	❍	❍
3. I would describe myself as a misfit at most Gay/Lesbian social events	❍	❍	❍	❍
4. I generally feel that people accept me in the Gay/Lesbian Community	❍	❍	❍	❍
5. Within the Gay/Lesbian community, I feel like a piece of a jigsaw puzzle that doesn't fit into the puzzle	❍	❍	❍	❍
6. I would like to make a difference within the Gay/Lesbian Community, but I don't feel that what I have to offer is valued	❍	❍	❍	❍
7. I feel like an outsider in the Gay/Lesbian Community	❍	❍	❍	❍
8. I am troubled by feeling like I have no place in the Gay/Lesbian Community	❍	❍	❍	❍
9. I could disappear for days and it wouldn't matter to others in the Gay/Lesbian Community	❍	❍	❍	❍
10. In general, I don't feel a part of the Gay/Lesbian Community	❍	❍	❍	❍
11. Within the Gay/Lesbian Community, I feel like I observe life rather than participate in it	❍	❍	❍	❍
12. If I died tomorrow, very few people from the Gay/Lesbian Community would come to my funeral	❍	❍	❍	❍
13. Within the Gay/Lesbian Community, I feel like a square peg trying to fit into a round hole	❍	❍	❍	❍
14. I don't feel that there is any place where I really fit in the Gay/Lesbian Community	❍	❍	❍	❍
15. I feel uncomfortable knowing that my background and experiences are so different from those who are in the Gay/Lesbian Community	❍	❍	❍	❍
16. I could not see or call my friends from the Gay/Lesbian Community for days and it wouldn't matter to them	❍	❍	❍	❍
17. I feel left out of things in the Gay/Lesbian Community	❍	❍	❍	❍
18. I am not valued by or important to people in the Gay/Lesbian Community	❍	❍	❍	❍

Appendix G

Visual Analogue Scales for Sense of Belonging to four Spheres of Community

For this question, place a tick in a circle above a number, to indicate how you are feeling right now.

Thinking about the *general community*, to what extent do you ……..

- feel needed or valued?

Not needed or Valued	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely valued

- feel that you fit in?

Do not fit in at all	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely fit in

Please read each question carefully, as each question is asking you to think about a different aspect of the gay/lesbian community. If you identify as male, answer the questions in relation to the GAY COMMUNITY; if you identify as female, answer the questions in relation to the LESBIAN COMMUNITY. For each question, place a tick in a circle above a number, to indicate how you are feeling right now.

1. Thinking about the *gay/lesbian community in general*, to what extent do you ……..

- feel needed or valued?

Not needed or Valued	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely valued

- feel that you fit in?

Do not fit in at all	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely fit in

2. Thinking about *gay/lesbian organisations* (including interest, social and support groups), to what extent do you

- feel needed or valued?

Not needed or Valued	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely valued

- feel that you fit in?

Do not fit in at all	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely fit in

3. Thinking about your *network of gay/lesbian friends*, to what extent do you ……..

- feel needed or valued?

Not needed or Valued	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely valued

- feel that you fit in?

Do not fit in at all	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10	Completely fit in

Placement Research Reports and Ethical and Professional Practice Report

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A Research Report submitted in partial fulfilment of the requirements

for the Doctor of Psychology (Clinical).

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October, 2011

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Statement of Authorship

Except where overt reference is made in the text of this manuscript, this body of work does not include information that has been published elsewhere or been removed in full or part from a thesis by which I have been eligible for or been awarded another degree or diploma. No individual's work has been used without appropriate acknowledgement.

Signature: _____

Date: _____

Preamble

The placement research reports and ethical and professional practice report were compiled based on my experiences on four clinical placements. These placements occurred over a three year period and involved working predominately with adult clients, but also with some child and adolescent clients.

The first of these placements was with the University of Ballarat Psychology Clinic. During this placement I was involved in the psychological assessment of adults, adolescents and children with learning or developmental issues. These assessments involved administering a number of structured psychometric tests and then integrating the results to form a detailed assessment of the client's psychological functioning. This process also involved writing detailed reports and meeting with education professionals and parents.

This placement was followed by a placement at Centrelink where I performed job capacity assessments. In this role I conducted a number of single session clinical interviews designed to determine the psycho-social functioning of jobseekers. These assessments were conducted to determine what additional support job seekers with issues such as a disability or on going illness required to gain employment. This role also involved conducting intellectual assessments and occasionally brief structured psychological interventions. Brief reports integrating information from the job seeker and other sources, such as doctors, were written.

For my third placement at Colac Area Health, I performed a number of psychological interventions with people presenting with anxiety, depression and substance abuse issues. I also conducted a number of single session intake interviews to facilitate counsellor allocation and treatment planning.

My final placement was at Marngoneet Correctional Centre. While at this prison I was involved in delivering offence specific interventions to both individuals and groups. I also performed a number of assessment interviews to determine the suitability of prisoners for involvement in offence specific programs.

Placement Report 1

A Single Participant Case Study evaluating the use of CBT for the Treatment of Generalised Anxiety Disorder

Acknowledgement: Counselling Services, Community Services, Colac Area Health

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Abstract

The central feature of Generalised Anxiety Disorder (GAD) is an excessive amount of anxiety or worry, about a number of situations or events. This disorder is relatively common in Australia, with a greater proportion of women experiencing this disorder than men. Theorists have argued that anxiety disorders tend to manifest in people prone to over estimating the level of threat and underestimating their ability to cope with this threat. The aim of Cognitive Behavioural Therapy (CBT) for anxiety is to alter the way that a person appraises their environment, so that any disproportionate sense of danger is reduced. The efficacy of this therapy in treating GAD is supported by recent research. In the current clinical case study, a 50-year-old woman was treated for GAD via 13 sessions of CBT. The results of this study indicate that the participant experienced less distress and fewer symptoms at the end of this treatment compared to the start of treatment. The results of this study provide further evidence for the efficacy of CBT for GAD.

Chapter 1: Introduction

1.1. Generalised Anxiety Disorder

Generalised Anxiety Disorder (GAD) is characterised by an excessive amount of apprehensive expectation, about a number of situations or events, for at least six months (American Psychiatric Association, 2000). For this worry and anxiety to be clinically significant, the person must have difficulty controlling this worry and it must be associated with at least three of six symptoms. These symptoms are restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and sleep disturbance. Some of these symptoms have to be experienced for at least more days than not for 6 months (American Psychiatric Association, 2000). This worry must not be attributable to another Axis I disorder and the individual must experience distress or impairment in important areas of functioning, such as social interaction, to an extent that is considered clinically significant. Finally, this anxiety cannot be attributable to substance use or a general medical condition nor occur exclusively during the course of a mood, psychotic or pervasive developmental disorder (American Psychiatric Association, 2000).

1.1.1. Prevalence Rates

A recent population survey in Australia found that the overall lifetime prevalence of this disorder in Australians, aged 16-85 years old, was 5.9% (Australian Bureau of Statistics, 2007). The lifetime prevalence of this disorder, within this age group, was higher in Australian women (7.3%) than in men (4.4%; Australian Bureau of Statistics, 2007).

1.1.2. Aetiology

There are a number of theories regarding the development and maintenance of GAD, with most theorists arguing that this disorder is a specific manifestation of an aetiology that is common to both mood and anxiety disorders (Beck, 1976; Beck, Emery, & Greenberg, 1985; Grey & McNaughton, 2000). This view of a common aetiology is supported by Watson's (2005) review of the correlational evidence in the literature and the modelling associated with it. The results of this review indicated that both mood and anxiety disorders share two dimensions, general distress and negative affectivity.

Gray and McNaughton (2000) used the results of animal and psychopharmacological research to develop a model to explain how anxiety disorders developed. They argued that mood and anxiety disorders develop from shared aetiologies, despite being distinct individual disorders. They argue that emotional regulation is a function of a variety of different brain areas that lead to a range of behaviours in response to threatening stimuli, depending on the specific brain area activated by the threat. They contend that six different brain areas that they link to these disorders are interconnected. Further, the functioning of these six areas is adversely affected by the genetically inherited personality trait of neuroticism.

Recent twin and family research has demonstrated a common genetic aetiology to anxiety, depression and neuroticism (Hettema, Neale, Prescott, & Kendler, 2006; Hettema, Prescott, & Kendler, 2004; Middledorp, Cath, Van Dyck, & Boomsma, 2005; South & Krueger, 2008). Environmental risk factors of neuroticism, anxiety and depression have only small correlations (Hettema et

al., 2006; Hettema et al., 2004; Middledorp et al., 2005). However, Hettema et al. (2006) in their US twin study found that environmental factors had high factor loadings, despite the low correlation between variables on these risk factors. These researchers argued that this result could be explained by the presence of non-shared experienced life stressors, environmental risk factors unique to a specific disorder or measurement error. Finally, Middledorp et al. (2005) in their meta-analysis of twin and family studies were unable to determine whether common genetic aetiology or interconnection between brain regions was more important in explaining the relationship between anxiety and depression. However, they argued that the research indicated that specific anxiety and mood disorders were unique disorders.

Beck et al. (1985) argued that anxiety disorders did not result from a single cause, but resulted from a number of factors (e.g. genetics, stressors, poorly developed coping and maladaptive thoughts) that could combine to predispose an individual to developing an anxiety disorder. They argued that people who develop this type of disorder tend to do so due to their self-perception of being inadequate in some way, so that they perceive themselves as being constantly vulnerable to either rejection or criticism. However, they contended that the onset of GAD extends back into the individual's developmental history and that precipitating stressors may trigger an individual's sense of vulnerability, but not create it.

According to the Cognitive Model of Emotional Disorders (Beck, 1976), psychological disorders result from difficulties that an individual has in organising and interpreting reality. These faulty perceptions lead to unrealistic thinking and self-defeating behaviour. Sufferers of anxiety disorders struggle to

stop thinking about danger, believe in the validity of these thoughts and generalise fear associated with one stimulus to other similar stimuli. These individuals have fixated attention on danger and signals that may indicate that something is dangerous, leading them to label non-threatening situations as dangerous.

Recent research provides further evidence that people can become fixated on signals that create distress (Mathews & Wells, 2000) and that they can learn to fear a novel stimulus (Otto et al., 2007). In their review of the experimental literature, Mathews and Wells (2000) found that there is a demonstrated tendency for people with emotional disorders to have selective attention that both creates and maintains their distress. A recent study by Otto et al. (2007) demonstrated a process that may explain how an anxiety disorder can develop in people with certain traits, but no history of an anxiety disorder. In this US study, some participants were conditioned to develop a fear response to a neutral stimulus. The researchers achieved this conditioning effect by associating a mild electric shock with the sight of a yellow square and not experiencing the shock with the white circle. The successful conditioning of participants was associated with a fear of anxiety symptoms, a tendency to worry and avoidant behaviour. According to uni-variate regression, both worry and fear of anxiety significantly predicted conditioning of a fear response to the neutral stimuli. However, only a fear of anxiety predicted the unconditioned response, increased skin conductance. Multivariate regressional analysis demonstrated that both worry and avoidant behaviours were strong predictors of a fear response to the conditioned stimulus. The number of anxiety symptoms that a person had did not predict conditioning.

1.1.2.1. Summary

Past research indicates that despite there being distinct anxiety and mood disorders, they share a common genetic aetiology (e.g., Hettema et al., 2006). However, these studies are less clear on how different disorders manifest from the one phenotype, but have proposed explanations, such as unique environmental risk factors for each disorder (e.g., Hettema et al., 2006). Research also demonstrates that people who are prone to worry, fear anxiety symptoms or use avoidant coping can be conditioned to experience fear when presented with a novel stimulus more easily than those with out these traits (Otto et al., 2007). Additionally, there is evidence that people with mood and anxiety disorders have fixated attention to stimuli that is associated with their mood or anxiety disorder (Matthews & Wells, 2000). Finally, Beck (1976) proposes that people prone to anxiety disorders over estimate the level of threat and underestimate their ability to cope.

1.1.3. Treatment-CBT for Anxiety

. Cognitive Behavioural Therapy for Anxiety (Beck et al., 1985) is based on the Cognitive Model of Emotional Disorders (Beck, 1976) and therefore is targeted at altering the way that the client appraises the situations that they are in (Beck et al., 1985). People with GAD tend to perceive non-threatening situations as threatening or underestimate their ability to cope with threatening situations (American Psychiatric Association, 2000; Beck et al., 1985; Wells & Matthews, 1994; Treatment Protocol Project, 2004). The aim of CBT for this condition is, therefore, to alter the client's maladaptive thoughts or beliefs that exacerbate distress, so that more adaptive thinking reduces this distress (Beck et al., 1985).

Beck et al. (1985) describe this CBT as a 'system of psychotherapy' that combines a number of techniques in order to achieve its aim of altering the client's faulty appraisals. Sessions include the discussion of homework and psycho-education and the development and practice of coping skills (Beck et al., 1985; Cormier & Nurius, 2003; Treatment Protocol Project, 2004). In their description of this therapy for anxiety, Beck et al. (1985) emphasised the importance of analysing the client's experience of anxiety through out the course of therapy. This assessment facilitates the client's understanding of their experiences, so that their level of distress is lowered. Additionally, homework is an essential component of this therapy as it facilitates the client's learning of how to apply what they have learned in therapy to everyday events that they encounter (Beck et al., 1985).

An essential component of CBT for anxiety is Cognitive Restructuring, the process of altering maladaptive thoughts and beliefs into adaptive thoughts and beliefs (Beck et al., 1985; Cormier & Nurius, 2003). Psycho-education is an important component of this therapy as it encourages the client's self-awareness, which allows the client to take a more objective view of their experiences (Beck et al., 1985). The process of thought challenging involves encouraging the client to question the validity of their automatic thoughts. This is achieved by the identification of these thoughts, when they occur, what evidence exists to support or refute these thoughts and alternative ways of thinking about the situation (Beck et al., 1985; Cormier & Nurius, 2003; Davis, Eshelman, & McKay, 2000). Reframing is a technique that facilitates the client's awareness of the features of a situation that they focus on when they feel anxious and encourages them to

focus on other features of the situation that are non-threatening (Cormier & Nurius, 2003).

Another important component of this therapy is modifying how the client emotionally responds to their anxiety (Beck et al., 1985). Psycho-education can also be used in this process, as it can reduce the client's fear of the anxiety, increase their acceptance of this emotional state and normalise their experience of it (Beck et al., 1985). The technique of breathing control can reduce any feelings of worry (Friedman & Thase, 2005) and physical symptoms associated with this worry (Treatment Protocol Project, 2004). This technique can give the client's a sense of mastery over their symptoms and give them greater self-awareness of how their physical state affects their emotional state (Beck et al., 1985).

Past research supports the efficacy and effectiveness of CBT for anxiety in treating GAD (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Khodarahimi & Pole, 2010; Montel, 2010; Siev & Chambless, 2007; Stewart & Chambless, 2009) and certain components of this therapy have been demonstrated to facilitate this process (Westra, Dozois, & Marcus, 2007). Two recent case studies provide evidence of the effectiveness of treating GAD with CBT for anxiety in female out patients in Iran and France respectively (Khodarahimi & Pole, 2010; Montel, 2010). A meta-analysis of the effectiveness studies of CBT for anxiety found a large treatment effect size for the treatment of GAD (Stewart & Chambless, 2009). A similar meta-analysis of the use of brief psychotherapies in primary care found that CBT was an effective treatment for anxiety disorders (Cape et al., 2010). Another meta-analysis found that the cognitive and behavioural components of CBT were equally efficacious in the

treatment of GAD, but the effect sizes were not as large as those that were reported for other anxiety disorders (Siev & Chambless, 2007). In a Canadian study of participants with a variety of anxiety disorders, homework completion was positively correlated with initial CBT treatment gains (Westra et al., 2007).

1.1.3.1. Summary

CBT for anxiety is a treatment that attempts to alter the way that a person appraises their environment (Beck et al., 1985). To achieve this aim CBT makes use of a number of techniques, including cognitive restructuring, breathing control (Beck et al., 1985) and reframing (Cormier & Nurius, 2003). Recent research indicates that this therapy has both efficacy and effectiveness in treating GAD (e.g., Siev & Chambless, 2007; Stewart & Chambless, 2009).

1.2. Aims & Hypothesis

The current study was a single participant case study aimed at demonstrating the effectiveness of using CBT to treat a client with GAD. It was hypothesised that at the conclusion of treatment, the client would be experiencing less distress, would report fewer symptoms of GAD and no longer meet the DSM-IV-TR diagnostic criteria for GAD.

Chapter 2: Method

2. 1. Participant

2.1.1. Reason for Referral

'Annie' (not her real name) is a 50-year-old woman, referred by her doctor for counselling, due to difficulty in managing stress and stress related headaches.

2.1.2. Presenting Issues

Annie described herself as having a tendency to be 'thin skinned' and others have said that she overreacts to bad news. She also mentioned that she found it difficult to express her own views and she stated that she avoids confrontation due to her belief that she may 'hurt them'. During intake, Annie mentioned that she wanted to talk to someone to help her move on from recent stressful events and help her understand her reaction to these events. She also wanted help in dealing with other people that she found difficult to deal with.

2.1.3. Family Constellation

Annie lives with her husband, who she describes as supportive and she reports a good relationship with her sons. Annie reported that she is from a small family with only one sibling and that her parents are still married and living together. She reported a difficult relationship with her mother, a closer relationship with her father and that she had grown distant from her sister.

2.1.4. Behavioural Observations

During sessions, Annie had a tendency to become teary or cry when describing distressing events and demonstrated a tendency to elaborate by describing life events in detail. She was also fidgety, expressed her confusion

about how people acted the way that they did and she demonstrated some irritability.

2.2. Measures

The measures used during this study consisted of the Kessler Psychological Distress Scale (K-10; Kessler et al., 2002), Global Assessment of Functioning (GAF) Scale (American Psychiatric Association, 2000), DSM-IV-TR Diagnostic Criteria (American Psychiatric Association, 2000) and clinical interviewing.

2.2.1. Kessler Psychological Distress Scale

The Kessler Psychological Distress Scale (K-10; Kessler et al., 2002) is a 10-item scale intended to measure the amount of psychological distress that the respondent has experienced *in reference to the past four weeks*. Respondents indicate the proportion of time that they were distressed in response to each item on a 5-point scale, from 1 = *None of the Time* to 5 = *All of the Time*. An example of the items on this scale is: *So restless or fidgety that you could not sit still?* Pilot and cross validation, studies in Australia and the US have demonstrated that this scale can discriminate individuals with a mental disorder from those without these disorders (Kessler et al., 2002). An Australian population study (Furukawa, Kessler, Slade, & Andrews, 2003) found that the K-10 was superior to the General Health Questionnnaire-12 (Goldberg & Williams, 1988) in discriminating participants with depressive or anxiety disorders from those who did not have these disorders. Additionally, the K-10 could provide information across the population, whereas the GHQ-12 was skewed towards those that did not have a disorder (Furukawa et al., 2003). The K-10 has adequate internal

reliability with an Australian population survey finding a Cronbach's alpha of .92 (Kessler et al., 2002).

2.2.2. Global Assessment of Functioning

The Global Assessment of Functioning (GAF) Scale (American Psychiatric Association, 2000) allows clinicians to measure an individual's psychological, social and occupational functioning, on a scale of 0-100. A score of 0 is given on this scale only when there is inadequate information to apply a higher score. When adequate information is available, the lowest score range is 1-10 = *Persistent danger of severely hurting self or others OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death*. The highest score range in these circumstances is 91-100 = *Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms*. Clinicians make this measurement, using their clinical judgment, based on the information that they have on the individual's functioning.

2.2.3. DSM-IV-TR Diagnostic Criteria

DSM-IV-TR Diagnostic Criteria (American Psychiatric Association, 2000) provides a guide for diagnosing specific mental disorders. Each disorder is categorised based on symptom cluster, number of symptoms present, significant level of functional impairment and by exclusionary criteria that helps differentiate a particular disorder from other disorders with similar symptoms. The intensity of disorder can be defined as *Mild* = just meeting the criteria, *Severe* = many symptoms are present or *Moderate* = number of symptoms or level of functioning is in between mild and severe.

Clinical interviewing, both semi-structured and non-structured, was used to gather information from the participant about her presenting issues. The client was interviewed initially using a semi-structured interview that consisted of questions regarding symptoms experienced, family relationships, issue of concern, medical and treatment history and reason for seeking help. The non-structured interviewing was focused on gaining more information about presenting issues, symptoms, family of origin, antecedents, behaviours and consequences and treatment goals.

2.3. Procedure for Assessment and Treatment

The participant attended 13 sessions, over a period of three and half months, with the typical gap between each session being about one week. The outline of each session is given below:

Session 1: This session consisted of semi-structured interview designed to facilitate case allocation. This intake screen contained questions identifying symptoms, emotional functioning, family relationships, issue of concern and medical history. The K-10 was administered as a part of this process.

Session 2: The clinician conducted a clinical interview with Annie to gain a better understanding of the context, frequency and intensity of her issues of concern and how counselling could address these concerns.

Session 3: The focus of this session was providing Annie with psycho-education around the nature and effects of anxiety. Additionally, clinical interviewing was used to gain a better understanding of the antecedents, behaviours and consequences associated with Annie's experience of anxiety. Homework: Annie was given written information on the nature and effects of Anxiety.

Session 4: The focus of this session was on breathing control and psycho-education around the use of this technique. Additionally, Annie was provided with written information about both breathing exercises. Homework: Practice breathing control and read the information given to her about this technique and its benefits.

Session 5: Annie wanted to discuss the difficult aspects of her past and she was allowed to do this. The effects of the breathing control technique were reviewed. At the end of the session the clinician asked her, for homework, to list situations that made her anxious and to rate how much distress they caused her, whether she avoided them or not and to rank them from the most anxiety provoking situation to the least.

Sessions 6-11: The focus of these sessions was on identifying irrational thoughts/beliefs, thought challenging and reframing, as well as providing her with psycho-education about these issues. During these sessions, Annie completed a thoughts beliefs inventory and a thought challenging exercise and we discussed her homework. The clinician gave her thought diaries to complete, for homework. She was also given written material, to read, on irrational thoughts/beliefs and thought challenging.

Sessions 12-13: The final two sessions involved monitoring her progress and encouraging her to continue to use the coping skills that she had learnt during the previous sessions. The K-10 was readministered during session 12. Additionally, during both sessions she was asked if she had noticed any differences in her behaviour and what these differences were if they existed. Homework: Continue using the techniques that she had learnt.

Chapter 3: Assessment and Results

3.1. K-10 and GAF Results

The assessment of the participant's level of psychological distress and functioning due to the symptoms present showed reduction in the former and an increase in the later across time at the end of treatment. The participant's initial score on the K-10 of 21 indicated the presence of a mild psychological disorder in the previous month. On the second administration of this test 3 months later, her score was 18, which indicated that no psychological disorder was present in the previous month. The assessment of the participant's GAF showed an increase, from GAF = 55, indicating the presence of moderate symptoms, to GAF = 70, three months later, indicating mild symptoms.

3.2. DSM-IV-TR Diagnostic Criteria

Table1 shows the DSM-IV-TR Diagnostic Criteria for GAD that the client met at the beginning and at the end of treatment. The results presented in Table 1 indicate that the client met the diagnostic criteria for a diagnosis of GAD at the beginning of treatment. At the end of treatment, Annie no longer met the diagnostic criteria for a diagnosis of GAD.

Table 1
Description of Diagnostic Criteria for Generalised Anxiety Disorder Present, Pre and Post Intervention

DSM IV-TR Criteria, Pre-Intervention	DSM IV-TR Criteria, Post-Intervention
● Excessive worry and anxiety for at least 6 months about a number of activities or events	● Excessive worry and anxiety for at least 6 months about a number of activities or events
● Difficulty in controlling this worry	
● Irritability	
● Muscle tension	
● Sleep disturbance	● Sleep disturbance
● Symptoms not better explained by another Axis I disorder	● Symptoms not better explained by another Axis I disorder
● Clinically significant distress or impairment in social, occupational or other important areas of functioning	
● Symptoms are not due to a substance, general medical condition or a mood, psychotic or pervasive developmental disorder.	● Symptoms are not due to a substance, general medical condition or a mood, psychotic or pervasive developmental disorder.

The behavioural indicators of anxiety and distress associated with this anxiety, pre and post-intervention, are shown in Table 2. As shown, whereas some physical and behavioural indicators of anxiety and distress were still present at follow up, many were not. The participant initially reported that sleep disturbance had stopped, but subsequently reported at 3-month follow up that this symptom had reoccurred in response to a specific stressor.

Table 2
Physical and Behavioural Indicators of Anxiety and Distress, Pre and Post-Intervention

Pre-Intervention	Post-Intervention
● Panic Attacks *	● Panic Attacks*
● Sleep disturbance	● Sleep disturbance*
● Muscle Tension	
● Headaches	
● Crying*	
● Avoidance*	
● Nail biting	
● Analysing	● Analysing
● Excessively detailed description of events	● Excessively detailed description of events

* = Situation specific reaction, all other indicators in table reoccurred frequently.

Chapter 4: Discussion

4.1. Aim of the Present Study

There is a substantial amount of research indicating the effectiveness and efficacy of CBT in treating anxiety. The aim of the present study was to demonstrate the effectiveness of treating a woman with GAD using CBT. It was proposed that this effectiveness would be demonstrated by a significant reduction in the number of GAD symptoms that the participant experienced and the distress she experienced because of these symptoms.

4.1.1. Hypothesis

The results of the current study support the hypothesis that after being treated with CBT the participant would experience less distress, report fewer GAD symptoms and no longer meet the diagnostic criteria for this disorder. The participant's results on the K-10 at intake and 3 months later indicate that her level of distress fell from mild to normal. Additionally, at the end of treatment she reported the absence of muscle tension, headaches, crying, avoidance and nail biting. At the beginning of the treatment, the participant met the diagnostic criteria for this disorder, but at the end of the study, the participant no longer did so. The participant demonstrated a greater capacity to control worry, no longer experienced muscle tension or irritability. Additionally, as indicated by GAF, she was no longer as functionally impaired or distressed as she was at the beginning of the intervention. These findings are consistent with the expected outcomes of this treatment (Beck et al., 1985). The results of the present study are also consistent with the results of recent research that support the efficacy and effectiveness of CBT for anxiety in treating GAD (Cape et al., 2010;

Khodarahimi & Pole, 2010; Montel, 2010; Siev & Chambless, 2007; Stewart & Chambless, 2009; Westra et al., 2007).

Beck et al. (1985) argued that CBT for anxiety works mainly through altering the client's faulty appraisals through the process of Cognitive Restructuring. Cognitive Restructuring replaces these faulty appraisals with adaptive thoughts and beliefs. Thought challenging (Beck et al., 1985; Cormier & Nurius, 2003; Davis et al., 2000) and Reframing (Cormier & Nurius, 2003) are specific techniques that the client can be taught to facilitate cognitive restructuring.

CBT also works as it alters the way that the client emotionally responds to their anxiety (Beck et al., 1985). CBT combines a thorough analysis of the client's experience of anxiety and Psycho-education to facilitate the client developing a more objective view and a greater understanding of these experiences, so that they feel less distressed (Beck et al., 1985). Psycho-education reduces the client's fear, increases their acceptance and normalises their experience of the anxiety (Beck et al., 1985). Another technique used to alter the client's response to anxiety is breathing control. This technique is believed to work as it reduces any feelings of worry (Friedman & Thase, 2005) and physical symptoms of anxiety (Treatment Protocol Project, 2004), and it increases the client's sense of control over their symptoms (Beck et al., 1985). Additionally, it is possible that this technique provides the client with insight into how their physical state affects their emotional state (Beck et al., 1985).

The homework completed during this therapy facilitates the client's leaning of how to apply the adaptive strategies that they have learned during sessions to their everyday experiences (Beck et al., 1985). Recent research

indicates that the completion of this homework is associated with outcomes that are more successful (Westra et al., 2007).

4.2. Limitations

The results of this study need to be considered in the light of the following limitations. As this was a single participant case study, the results found for this participant may not be representative of all people with GAD undergoing this treatment. Additionally, these results are based on descriptive statistics, so no inferences about the statistical significance of these results can be made. It is also not possible to isolate specific treatment effects for different components of this intervention or to determine if all treatment effects were due to the intervention or if other factors such as changes in the participant's environment had an effect.

4.3. Conclusion

The present study demonstrated that CBT was an effective treatment for a participant being treated for GAD. The participant experienced less distress and symptoms at the end of this intervention than they did at the beginning. In addition, the participant no longer met the criteria for a diagnosis of GAD and her functioning had improved. These results are consistent with past literature on the efficacy of CBT for GAD.

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Placement Report 2

A Single Participant Case Study Evaluating an Ambivalence to Change Intervention for a Violent Offender

Acknowledgement: Clinical Services, Corrections Victoria, Department of Justice (Marngoneet Correctional Centre)

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Abstract

Many offenders are ambivalent about change, so reducing this ambivalence is an important treatment target for this population. Motivational interviewing was developed to treat ambivalence to change. The Trans-theoretical Model describes several stages of change and Motivational Interviewing is considered an effective method to move people form one of these stages to the next. A violent offender in his early twenties underwent seven sessions of individual therapy that utilised motivational interviewing. It was predicted that the participant's stage of change would alter, with a reduction in his ambivalence to change. Although the participant's stage of change moved to a higher stage for some problem behaviour, it moved to a lower stage or remained the same for other behaviours. These unexpected results can be explained by a number of factors.

Chapter 1: Introduction

1.1. Treatment Readiness in the Criminal Justice System

1.1.1. The Change Process among Offenders

There is little sympathy for offenders in society and the traditional view is that the focus of the Criminal Justice System should be on punishing offenders (Ginsburg, Mann, Rotgers, & Weekes, 2002). Additionally many mistakenly believe that punishment reduces reoffending (Ginsburg et al., 2002). This mentality has led to programs in corrections settings, such as boot camps in the US, which emphasise external control and confrontation in dealing with offenders (Ginsburg et al., 2002). Some offenders, especially those that reoffend, are prepared to resist the coercive sanctions of the Criminal Justice System and this resistance can lead to a lower likelihood of change (Ginsburg et al., 2002). Past research indicates that many offenders in programs are poorly motivated and lack treatment readiness (e.g., Vandevelde, Broekaert, Schuyten, & Van Hove, 2005). Offenders are often mandated clients and may perceive participation in therapy as coerced (Ginsburg et al., 2002). This can lead to offenders merely going through the motions, by participating in programs to a minimal extent or increasing their problem behaviour (Ginsburg et al., 2002).

1.2. Motivation as the Focus of Treatment

1.2.1. Motivational Ambivalence

Ambivalence to change among offenders is often due to their offending fulfilling certain goals and by so doing so this offending is serving a particular function (McMurran & Ward, 2004). Moreover, insisting that the offender cease offending can be like asking them to surrender something of value (McMurran & Ward, 2004). According to Miller and Rollnick (2002) ambivalence is a natural

state that people pass through on their way to change and that it only becomes a problem if the person becomes stuck there for a prolonged period. As offenders can become stuck in this state, this ambivalence should become the focus of a brief intervention aimed at enhancing the motivation of offenders (McMurran & Ward, 2004; Miller & Rollnick, 2002). To achieve behavioural change, the identification and alteration of the factors that contribute to the offender's current state of motivation is required (McMurran & Ward, 2004). It is also necessary to help them identify goals that are of value to them and appeal to their self-interest in abstaining from offending (McMurran & Ward, 2004).

1.2.2. The Theoretical Basis of Motivational Interviewing

According to Miller and Rollnick (2002), Motivational Interviewing has been developed specifically to deal with ambivalence to change. Miller and Rollnick describe it as a person centred approach, as it is focused on the perceptions and concerns of the client. However, they also describe it as a directive approach, as the therapist responds to the client and reinforces the client selectively, in a way that moves the client towards change. They describe how this form of interviewing is also focused on change that is driven by the individual's internal functioning rather than any external pressure or force, even when the client is a mandated client. Finally, they point out that due to its nature, motivational interviewing can only achieve change that is consistent with the values and beliefs of the client. Therefore, the role of the therapist, according to these theorists, is to facilitate natural change. Motivational Interviewing is therefore a form of communication rather than a collection of techniques. In Motivational Interviewing, they explain, it is important that the therapist facilitates the client's *self-efficacy*, a person's belief in their capacity to succeed

at a given task. This is achieved, they argue, by the therapist actively increasing the client's confidence in over coming barriers to change and achieving change.

Miller and Rollnick (2002) also argue that for a person to see change as important they need to develop a perceived discrepancy between their perceived goals and their perception of their own current behaviour. Goals are envisioned as states that a person deliberately sets out to achieve or avoid (Karoly, 1993). An individual will select goals based on their current beliefs on what the possible outcomes of their life are at that point, so goals are provisional rather than fixed or stable (Karoly, 1993). According to Miller and Rollnick (2002), the greater the perceived gap between perception of behaviour and goals the more important change becomes to the individual. This discrepancy grows with any changes in the perception of behaviour and goals, including the meaning or value that they attribute to these goals or behaviours (Miller & Rollnick, 2002). Ambivalence develops because of this discrepancy between goals and behaviours and as this discrepancy increases ambivalence at first intensifies, but then is resolved with change (Miller & Rollnick, 2002). It is important therefore, to facilitate the client in identifying the discrepancy between their problem behaviour, such as offending, and achieving their goals (McMurran & Ward, 2004).

Another process that Motivational Interviewing facilitates, in order to achieve change, is the *decisional balance* (Miller & Rollnick, 2002). The decisional balance is when an individual weighs up the pros and cons of changing and not changing problem behaviour (Miller & Rollnick, 2002). The individual's decision about whether the pro and cons for change out weigh those for not changing, is not based simply on them counting the number of pros and subtracting number of cons. The value that the person applies to each pro and

con can vary from one to the next and it can also vary over time (Miller & Rollnick, 2002). Individuals are often unaware of the existence of this decisional balance when maintaining or attempting to change behaviour (Miller & Rollnick, 2002). When they become aware of this decisional balance during an intervention, they will not necessarily respond to this knowledge in a rational manner (Miller & Rollnick, 2002).

1.2.3. Motivational Interviewing in the Criminal Justice System

Motivation, in the criminal justice system, can be defined as a willingness to either engage and participate in treatment programs or alter criminal behaviour (Ginsburg et al., 2002). Motivational Interviewing can be used in a variety of ways with offenders (Ginsburg et al., 2002). It can be used to reduce reoffending, the consideration of and commitment to change or engagement and commitment to treatment (Ginsburg et al., 2002). When working with offenders it is possible to use Motivational Interviewing either as a primary intervention or as a treatment adjunct (Ginsburg et al., 2002).

Previous research indicates that Motivational Interviewing enhances treatment readiness in the general population (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010), as well as among offenders (Ginsburg et al., 2002; McMurran, 2009; Mendel & Hepkins, 2002; Salvert, Stein, Klein, Colby, & Barnett, 2005; Stein et al., 2006). Meta-analysis of a large number of Motivational Interviewing studies found that this communication style increases the participants' willingness to change problem behaviours and their engagement in treatment (Lundahl et al., 2010). In their review of the literature, Ginsburg et al. (2002) concluded that there is some evidence of the efficacy of Motivational Interviewing with the offending population. McMurran's (2009) systematic

review of the literature indicated that most of the studies reviewed found that Motivational Interviewing increases offenders' motivation for change, but some of these studies did not find this. One UK study of offenders with alcohol abuse issues and a learning disability (Mendel & Hepkins, 2002) found that three sessions of Motivational Interviewing increased the motivation of six out of seven participants. Additionally, this study found that three out of the seven participants increased their level of self-efficacy. The results of a US study (Salvert et al., 2005) indicate that using Motivational Interviewing with incarcerated juvenile offenders and their parents significantly increased the offenders' motivation and confidence to reduce their drug use. Another US study of incarcerated adolescents (Stein et al., 2006) found that Motivational Interviewing increased their treatment engagement.

1.3. Trans-theoretical Model

1.3.1. The Stages of Change

The Trans-theoretical Model attempts to explain how people progress through discrete stages of change (Prochaska, DiClemente, & Norcross, 1992). There are five distinct stages of change in the Trans-theoretical Model, described by Prochaska et al. (1992). The first of these stages is *Pre-contemplation*, which is when the individual does not consider the need to change. At the next stage, *Contemplation*, the individual recognises the need to change, but has not made any effort to do so. The *Preparation* stage is when the individual intends to take action in the near future or has taken non-sustained action in the recent past. When the individual reaches the *Action* stage, they are actively making changes to overcome their problems. Finally, at the *Maintenance* stage the individual is able to maintain these changes across time.

Although these stages were originally conceived as being linear, more recently the relationship has been described as a spiral (Prochaska et al., 1992). This change is due to the recognition of *relapse*, when an individual fails to maintain their changed behaviour and returns to their pre-existing problem behaviour (Prochaska et al., 1992). In this way, a person may return to an earlier stage of change, after reaching one of the latter stages (Prochaska et al., 1992). Some of these individuals will give up because of the relapse, while others will persist (Prochaska et al., 1992).

West (2005) is critical of the stages of change, as he argues that these are artificial stages created by researchers that actually do not exist. Further, this commentator argues that the stages of change assumes that people develop plans that are stable and coherent. He is also critical of how the stages of change focuses on conscious planning and decision making, ignoring the unconscious elements of motivation. Etter and Sutton (2002) point out that the stages of change consist of four different variables, intention to change, previous attempts at change, current behaviour and duration of current behaviour. They are critical of what they describe as the haphazard manner that these four variables are brought together in the stages of change. Additionally, they argue that the stages of change do not assess any of these variables comprehensively enough.

Despite these criticisms there is some evidence that the stages of change predict treatment outcomes in a variety of populations, including offenders (Heather, Hönekopp, & Smailes, 2009; Scott & Wolfe, 2003). A UK study found that those in the preparation and action stages, consistent with the predictions of the Trans-theoretical Model, reduced problem drinking behaviour more than those in the pre-contemplation and contemplation stages (Heather et

al., 2009). Convicted wife batterers in the UK, who were in the contemplation and action stages at the beginning of treatment, achieved more positive changes in problem behaviours than offenders in the pre-contemplation stage (Scott & Wolfe, 2003).

Some of studies provide evidence that the decisional balance is in involved in participants changing stages (Hildebrand & Betts, 2009; Ko et al., 2010; Schuman et al., 2005). A study of drug-addicted inmates in Taiwan (Ko et al., 2010) found that the decisional balance and self-efficacy were not significantly different between inmates at different stages of change. Although this finding was inconsistent with their initial predictions, the changes in these variables were in the expected direction. In contrast, Hildebrand and Betts (2009) found that the decisional balance and self-efficacy were significantly different between the stages of change among US parents feeding children fruit and vegetables. Their results indicate that the cons of change outweigh the pros in the earlier stages, with the reverse occurring during the preparation stage onwards. A study of US smokers (Schuman et al., 2005) found that only the pros of change was significantly different between participants at different stages of change and an increase in pros was associated with quitting smoking.

1.3.2. Motivational Interviewing and the Stages of Change

Both motivational interviewing and the Trans-theoretical Model consider change to be the responsibility of the client and that this change occurs through out a person's life, not just within the context of a therapeutic intervention (DiClemente & Velasquez, 2002). Motivational interviewing is considered a useful therapy for people who are in the earlier stages of change, especially pre-contemplators and contemplators (DiClemente & Velasquez, 2002). People in

these stages are not yet ready to make commitment to change with the latter only differing from the former in that they see change as a possibility (DiClemente & Velasquez, 2002). Motivational interviewing is also useful for those people in the later phases of change, but the emphasis is more on encouraging action rather than change (DiClemente & Velasquez, 2002). Motivational interviewing and the stages of change are often seen by researchers and practitioners as compatible (DiClemente & Velasquez, 2002).

1.4. Aims & Hypothesis

The aim of the present study was to evaluate the effectiveness of Motivational Interviewing in reducing an offender's ambivalence towards change. It was hypothesised that as an offender's ambivalence to change for offending related behaviours is reduced, his stage of change would move from a lower stage to a higher stage.

Chapter 2: Method

2. 1. Participant

2.1.1. Reason for Referral

'Peter' (not his real name) is a man aged in his early 20s, serving a sentence for a violent robbery that was related to his abuse of illicit substances.

2.1.2. Presenting Issues

Peter described himself as a person who was constantly in and who had a poor reputation in his locality. He mentioned an extensive history of violence, as both a perpetrator and a victim, as well as an extensive drug abuse history. A substantial proportion of his life had been spent in custody and he had a long criminal history. Although he had managed to have legitimate employment when living in the community, he also occasionally lived of the proceeds of crime. During the first session, he said he wanted to reduce his drug usage and change his violent criminal lifestyle.

2.1.3. Family Constellation

Peter reported that he had been a ward of the state as a child and that he had lived with numerous foster families. When growing up he had been exposed to violence in his family of origin and in his foster families. Although, Peter has had a difficult relationship with some members of his biological family, he has established a relationship with both of his natural parents. As Peter was growing up he developed close relationships with some of his extended family and he has maintained contact with several foster siblings.

2.1.4. Behavioural Observations

Peter appeared to be a healthy young man who often appeared confident when greeting the therapist in a foyer. However, when in the therapy room he

would occasionally report a lowered mood. During sessions he often spoke in slang, especially prison slang, for example using words such as ‘critters’, ‘dog’ and ‘Jacks’ and phrases such as ‘kicking along with it’. Through out the sessions Peter maintained good eye contact and the rapport with the therapist appeared adequate.

2.2. Measures

2.2.1. Stages of Change Cards

The Stages of Change Cards, developed by Corrections Victoria for use with the *Exploring Change* group program (Grey, 2011), are A4 sized yellow laminated cards that have black writing on both sides. On one side of the card, the name of a particular stage is printed, on the other side is a phrase describing that stage. For example the *Pre-Contemplation* card has the phrase *I like what I’m doing, I have no real desire to change* printed on the reverse side. These cards were placed on the floor, so that only the phrase associated with a stage, not the name of the stage, was visible. The participant then walked around reading these phrases before deciding which phrase best fitted his current stage of change for a particular offence related behaviour. When the participant had made his selections, the selected cards were turned over and the name of the stage revealed.

2.3. Procedure for Assessment and Treatment

The participant attended seven sessions over a period of six weeks, usually once a week, but he was seen twice in a week, once. The content of sessions was derived from *Exploring Change* group program (Grey, 2011) and adapted to suit a single client. This program content was designed to facilitate the client arguing the benefits of change, developing self-efficacy to change,

identifying their decisional balance and identifying how their problem behaviour prevented them from achieving their goals. The outline of each session is given below.

Session 1: The focus of this session was to introduce the general aim of treatment to the participant and outline future sessions, as well as develop rapport. During this session, a participation agreement was developed between the participant and the therapist.

Session 2: During this session, the reasons that the participant wanted to change, past attempts he had made and any ambivalence towards change was explored. During this session, the participant was asked a series of questions about change, including reasons for change and reasons change can be difficult. This led to a discussion abut the participant's past attempts at change and about his ambivalence towards change.

Session 3: Exploring the advantages and disadvantages, as well as the short and long-term consequences of offending, was the focus of this session. This session began with the participant completing a decisional matrix, with headings for the columns being advantages and disadvantages and the headings for the rows being offending and not offending. The outcome of this exercise was then discussed in length. The participant was then asked to describe a past offence and three consequences of this offence. The completion of this task was followed by a detailed discussion of the participant's responses. For homework, he was given a handout to complete about the positives and negatives of violence and the consequences of violence.

Session 4: The aim of this session was to introduce the stages of change and encourage the participant to identify which stage he was at, in terms of his

offending. As he did not complete his homework from the previous session there was no discussion of it. The *Stages of Change* Cards were placed on the floor and the participant was asked to identify his stage of change according to the different problem behaviours that he nominated. This task was then discussed. The therapist then introduced the stages of change in more detail explaining each of the stages and the concepts of lapse and relapse. This was followed by a discussion about how he has moved through the stages of change in regards to a particular offending behaviour. He was then provided with a hand out that explained each of these stages. When he had finished reading the handout he was then given the opportunity to again rate his stage of change, but this time only relating to offending behaviours. His choices were then discussed with the therapist.

Session 5: The aim of this session was to encourage the participant to identify his goals, the inconsistency between these goals and his offending behaviour and the changes required to achieve his goals. The homework from session three was discussed and he described ways that he could have dealt with the trigger for his current offence without resorting to violence. The participant was asked to nominate a future personal hope, aspiration or ambition, which was then discussed. This was followed by the participant walking along an imaginary line across the floor of the room. The participant was instructed to discuss at the beginning, midpoint and end of this imaginary line where he hoped to be at this point in regards to interpersonal relationships, employment and home life. The participant then completed a 'Looking Ahead' hand out, which the required the participant to write where they hoped to be at three different future time points,

that they nominated. The remainder of the session involved a discussion of how the participant's offending behaviour prevented him from achieving his goals.

Sessions 6: The purpose of this session was to allow the participant to identify aspects of his life that assist or prevent him from changing. Additionally, it was intended that he would identify personal strengths, as well as external supports. The participant was then asked to select a *strength card* that he believed represented strengths that he possessed. Each of these cards had a cartoon representing a strength, as well as the name of the strength. The participant was then asked to describe the strength, how it had been useful in the past and how it could assist him changing his problem behaviour. After this exercise, the participant brainstormed characteristics that would facilitate change and barriers that would hinder it. There was insufficient time left to explore external supports during this session.

Sessions 7: The aim of this session was to review the participant's participation and learning during this treatment and for him to identify external supports. The session began with the participant being asked to identify his external supports, which were then discussed. This was followed by a discussion of what the participant had learnt from this treatment and the participant's reflections on its content. The therapist also provided the participant with some feedback about his progress during the sessions, issues he needed to keep in mind and participation in other treatment. During this session, his stage of change was assessed again.

Chapter 3: Assessment and Results

3.1. Self-Reported Stage of Change

The participant's self-reported stage of change, at Time 1 and 2, is presented in Table 1. He placed himself at different stages depending on the problem behaviour. As presented in Table 1, Peter rated his stage of change for all problem behaviours at Time 2 at the preparation stage. Overall, he rated his stage change at lower stage at Time 2 than he did for Time 1.

Table 1

Stage of Change (SOC) for Various Problem Behaviours, During and Post Intervention

Problem Behaviour	SOC Time 1	SOC Time 2
Amphetamine Use	Contemplation or Preparation	Preparation
Methamphetamine Use	Maintenance	Preparation
Drug Dealing	Contemplation	Preparation
Violence	Action or Maintenance	Preparation

Chapter 4: Discussion

4.1. Aim of the Present Study

The results of previous studies indicate that Motivational Interviewing enhances treatment readiness among offenders (Ginsburg et al., 2002; McMurran, 2009; Mendel & Hepkins, 2002; Salvert et al., 2005; Stein et al., 2006). Motivational Interviewing was developed to address ambivalence to change (Miller & Rollnick, 2002). It is often seen as an effective treatment for clients to higher stages of change (DiClemente & Velasquez, 2002). Therefore, the aim of the present study was to investigate how effective this treatment was in reducing an offender's ambivalence towards change and increasing his stage of change, in regards to offending behaviours.

4.1.1. Hypothesis

The results of the present study indicate that support for the hypothesis that the offender's stage of change would move to a higher stage as his ambivalence towards change was resolved, depended on the particular offending behaviour assessed. There was some support for this hypothesis when considering drug dealing, but less support for amphetamine use. However, the hypothesis was not supported for methamphetamine use or violence.

The finding that the participant's stage of change moved to a higher stage for drug dealing is consistent with the expectation that Motivational Interviewing moves a person up through the stages of change (DiClemente & Velasquez, 2002). This result suggests that the stage of change has changed for drug dealing to a small extent, with the participant moving from considering change possible to deciding to change this problem behaviour. A key component of the present treatment was the decisional balance, which has been shown in previous research

to be associated with higher-level stages of change in non-offender populations (Hildebrand & Betts, 2009; Schuman et al., 2005). A study of Taiwanese inmates found that higher stages change were associated with a greater amount of change in the decisional balance, but this amount of change was not significantly different from the lower stages (Ko et al., 2010).

The current research also found results that were inconsistent with the use of Motivational Interviewing resulting in movement from a lower stage of change to a higher stage (DiClemente & Velasquez, 2002). Unexpectedly, the results of the present study indicate that the offender's stage of change moved from a higher stage of change to a lower stage. There are a number of possible explanations as to why these unexpected results were found (Brogan, Prochaska, & Prochaska, 1999; DiClemente & Velasquez, 2002; Miller & Rollnick, 2002; Prochaska et al., 1992; Scott & Wolfe, 2003). It is unlikely that this regression was due to not understanding the different stages of change or the concept of change, as this had been taught over several sessions. It is possible that the participant experienced a relapse that he did not disclose to the therapist and according to the Trans-theoretical Model (Prochaska et al., 1992) this would have led to movement to a lower stage. Another possibility is that his level of ambivalence increased during the intervention. Miller and Rollnick (2002) argue that the natural process of ambivalence is for it to first intensify then resolve in the direction of change. Therefore, it is possible that his regression from higher to lower stages was reflective of his ambivalence to change intensifying.

Additionally, previous US research indicates that clients that prematurely exit therapy tended to blame their problems on their environment and so were focused on environmental change rather than changing themselves (Brogan et al.,

1999). This is consistent with the participant's insistence that there were many environmental barriers preventing him from changing. Although this might explain the participant's level of motivation, it does not explain his regression from higher stages of change to a lower stage of change. However, it is possible that his perception of his problems as external undermined his level of self-efficacy in achieving change. Moreover, both Motivational Interviewing and the Transtheoretical Model place the responsibility of achieving change on the client (DiClemente & Velasquez, 2002). The participant's insistence on externalising his problems may indicate a lack of personal responsibility when it comes to achieving change. The client's inability to identify supports and his emphasis on barriers may also represent a lack of willingness to accept responsibility for behavioural change. Similarly, the intervention may have led to an increase in his ability to identify accurately his stage of change, due to an increased awareness of his lack of change, at that time, and the difficulty in changing behaviour. It is possible, therefore, that his identification of his stage of change at Time 2 was more realistic than it was at Time 1.

Another possibility explaining his regression from higher to lower stages of change is increased openness about his level of change (Scott & Wolfe, 2003). A study of UK wife batterers (Scott & Wolfe, 2003) found that participants in the pre-contemplation stage rated their behaviours towards their wives, at pre-treatment, more positively than batterers at higher stages of change. Scott and Wolfe concluded, therefore, that changes in variables for pre-contemplation participants probably reflected changes in openness and honesty, more than it did change in problem behaviour.

The result that Peter did not appear to move from preparation stage for amphetamine use is also inconsistent with the argument that motivational interviewing increases a person's stage of change (DiClemente & Velasquez, 2002). Previous research suggests that his age, early twenties, may have influenced his inability to change stages. Armitage, Sheeran, Conner, and Arden (2004) found that age predicted regression from the action stage and progression from the contemplation and action stages in a US study of healthy food choices. However, they also found that younger participants tended to not to change stages in either direction. In a similar study, Arden and Armitage (2008) found that moving from the pre-contemplation stage, for condom carrying behaviour, was predicted by increasing age. Therefore, Peter's lack of change in stage of change for amphetamine use may reflect that he still desires change, but he has not yet acted on this intent. However, this lack of change could have resulted from the participant's initial rating of the stage of change for this variable being more accurate.

4.2. Limitations

The results of this study have to be considered in the context of a number of limitations. The study only involved one participant, who may not be representative of incarcerated violent offenders. The measure used in this study was a one item self-report measure, with unknown psychometric properties. As the previous discussion indicates, it is possible that other factors, in addition to or other than his actual motivational change, may have affected the participant's response to this measure. These factors may have included his understanding of the model or the change process, increasing scepticism in his own ability to or interest in change and denial of problem behaviour. The lack of measurement of

these other factors in the present study makes it difficult to determine the influence of these factors. It is possible that the short space of time between Times 1 and 2 did not allow for sufficient time lapse to accurately measure changes in the participant's stage of change.

4.3. Conclusion

The present study demonstrates that a number of factors may influence an offender's perception of their stage of change. These results do not indicate the effectiveness of Motivational Interviewing in reducing an offender's ambivalence to change. There are many possible explanations, both theoretical and research derived, as to why this study has found inconsistent results. This study demonstrates the complexity of change attitudes in prisoners and difficulties in treating ambivalence in prisoners.

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Placement Report 3

An Evaluation of a Group Intervention for Violent Offenders

Acknowledgement: Clinical Services, Corrections Victoria, Department of Justice (Marngoneet Correctional Centre)

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Abstract

As criminal behaviour serves a functional purpose for offenders, treatment programs have been designed to teach offenders new skills, attitudes and values to encourage pro-social behaviour. The aim of the present study was to test the effectiveness of a group intervention program for violent offenders that included Cognitive Behavioural Therapy and Dialectical Behavioural Therapy techniques. Five inmates aged between 32 and 52 years (M = 43.80, SD = 7.56) participated in the study. The hypothesis that participation in the program would be associated with less interpersonal hostility, increased emphatic and less impulsivity was partially supported. There was partial support for the hypotheses that participation would be associated with less intensity and frequency anger experience and better management of anger experiences. The current study provides some evidence of the effectiveness of this program in treating frequency of anger, emotional management and impulsivity among violent offenders.

Chapter 1: Introduction

1.1. Treatment Goals

1.1.1. The Functionality of Criminal Behaviour

Ward and Stewart (2003a, b) have proposed a theory of prisoner rehabilitation that combines elements of several earlier theories (e.g., Andrews & Bonta, 1998; Deci & Ryan, 2000). According to Ward and Stewart's model, all human goals and desires partially result from the pursuit of basic human needs, such as relatedness and autonomy. They argue that if these needs are not fulfilled the individual will either be harmed or have an increased risk of future harm. For an individual to be able to fulfil these needs, they contend, certain psychological and environmental conditions are required. Environmental conditions such as culture and education facilitate the development of the psychological conditions such as skills and values (Ward & Stewart 2003a).

According to Ward and Stewart (2003a), a distortion of these environmental and psychological conditions results in the occurrence of *criminogenic needs*. These needs are characteristics of an offender and their environment that facilitate their offending (Andrews & Bonta, 1998). Ward and Stewart argue that the development of criminogenic needs hinder the optimal achievement of the basic needs. They explain that as the individual is hindered in meeting their basic needs there is a reduction in their psychological and social functioning, making it more difficult for this individual to have a fulfilling life. They argue, therefore, that the best way to reduce the likelihood of reoffending is to create conditions that allow the offender to meet their needs in a way that leads to a fulfilling life.

1.1.2. Relapse Prevention

The Good Lives approach proposed by Ward and Stewart (2003a, b) aims to achieve relapse prevention by improving the offender's life so that they no longer need to use criminal activity to meet needs. In contrast, the aim of relapse prevention based on the risk-needs model is to identify factors that increase an offender's chances of reoffending and find ways in which to reduce or eliminate these risks (Gredicki & Turner, 2009; Schaffer, Jeglic, & Wnuk, 2010; Thakker & Ward, 2010; Ward & Stewart, 2003b). These risk factors are specific cognitive, affective, behavioural, interpersonal or situational features that are associated with the offender committing an offence (Ward & Stewart, 2003b). An offender may lack motivation to participate in an intervention designed to reduce or eliminate risk factors, due to perceiving these factors as valuable aspects of their life (McMurran & Ward, 2004; Ward & Stewart, 2003b). Although the risk-needs approach can facilitate the offender's development of wellbeing this is not the principle aim of this approach (Thakker & Ward, 2010).

These approaches are not mutually exclusive, as it is possible to combine both of these approaches into a single relapse prevention intervention (Thakker & Ward, 2010; Ward & Stewart, 2003b). According to Ward and Stewart (2003b), by combining these approaches the therapist will have the best opportunity to understand what motivates offender's criminal behaviour while building a strong therapeutic alliance. These two approaches can be integrated together, by considering risk factors as barriers that prevent the offender from leading a pro-social and fulfilling life (Ward & Stewart, 2003b). Once identified, Ward and Stewart argue that the focus of relapse prevention is not to reduce or eliminate risk factors. Instead, the aim of the intervention becomes addressing

these factors with new skills, beliefs, supports and values that facilitate the development of a pro-social and fulfilling life.

1.2. Antecedents of Criminal Behaviour

1.2.1. Offence Process

To identify risk factors that contribute to offending the therapist needs to develop a formulation of why and how the offender commits crimes (Polascheck, 2003). The *offence process* consists of identified cognitive, affective and behavioural factors that contribute to the offender's criminal behaviour (Polascheck, 2003). Various models of offence process have been developed based on the outcomes of research on sexual offenders (Polascheck, 2003). According to Polascheck's (2003) review of the literature, the most effective framework for offence process is a linear chronological structure. In this way the offender is asked to consider the background and lead up to the offence and what occurred during and after the offence (Polascheck, 2003).

1.2.2. Emotional Functioning in Criminal Behaviour

Theorists have argued that emotions are often antecedents to criminal behaviour (Day, 2009; Howells, Day, & Wright, 2004; Marshall, Marshall, Serran, & O'Brien, 2009; Schaffer et al., 2010). *Emotions* are brief affective states that result from conscious information about a specific circumstance (Howells & Day, 2006). In their review of the sex offender literature, Howells et al. (2004) found that past research indicates that emotions influence how offenders select and pursue goals. They noted that theorists consider emotions important in achieving goals, as they tend to occur when the individual needs to perform at their optimum to achieve an important goal. When emotions are experienced extremely intensely or for long period, however, they can hinder the

individual's pursuit of their goals through limiting the individual's functioning (Howells et al., 2004). Research according to Howells et al. suggests that negative mood and emotion are related to reoffending. They concluded that the presence and absence of emotions and moods were important antecedents to offending. Their review indicates that offenders may be developmentally lacking in the regulation of negative emotions, so that they behave inappropriately when experiencing these emotions.

1.2.3. Cognitive Distortions

Another antecedent to offending are thoughts or beliefs that justify or encourage this behaviour (Barriga & Gibbs, 1996; Egan, McMurran, Richardson, & Blair, 2000; Marshall et al., 2009; Ross, Fabiano, & Ewles, 1988). Ross et al. (1988) argued that violent offenders tend to have cognitive deficits, developmental in origin that hinders their capacity to understand the behaviours, thoughts and feelings of others. These deficits decrease the likelihood of them being able to resolve interpersonal conflict in a pro-social manner and limit their development of social skills (Ross et al., 1988). The term *cognitive distortion* applies to faulty thoughts, beliefs or attitudes that can facilitate maintaining or justifying criminal behaviour through the externalisation of blame (Barriga & Gibbs, 1996; Egan et al., 2000; Marshall et al., 2009) or perceiving this behaviour positively (Egan et al., 2000). Treatment of offenders needs to address the faulty cognitions that facilitate the offender denying responsibility for their crime or justifying their criminal behaviour (Egan et al., 2000; Ross et al., 1988).

1.3. Group Intervention with Criminal Offenders

1.3.1. Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is used to treat cognitive distortions, manage negative or difficult emotions and lack of interpersonal skills and empathy in offenders (Schaffer et al., 2010). This form of therapy is based on the premise that how an individual appraises and constructs their environment affects how they react to and therefore experience their environment (Howells et al., 2004). Two recent studies have explored the treatment effects of CBT on the experience and expression of anger (Blacker, Watson, & Beech, 2008; Mela et al., 2008). Blacker et al. (2008) found a significant difference in how intensely incarcerated British men experienced anger after participating in a group programme that included elements of both CBT and drama therapy. They also found that participation in this programme resulted in a significant reduction in the frequency of anger experienced and improvement in the emotional management of anger. Similarly, Mela et al. (2008) found that Canadian violent offenders reported less frequency in the experienced anger after participating in a CBT based community anger group program. These researchers also found that their participants reported improved emotional management of anger experiences after the completing the program. There is also some evidence that CBT programs reduce re-offending or aggression in offenders (McGuire et al., 2008), violent partners (Lawson, 2010) and violent psychiatric patients (Davidson et al., 2009; Haddock et al., 2009).

1.3.1.1. Integrating CBT with Relapse Prevention

In their meta-analysis Dowden, Antonowicz, and Andrews (2003) found that programs that utilised CBT in addressing criminogenic needs and relapse

prevention were more effective in reducing re-offending than non-CBT programs focused exclusively on relapse prevention. They also found that interventions that treated specific elements of relapse prevention had a stronger association with a reduction in re-offending. These elements included identifying the offence process and high-risk situations and role-playing both, as well as addressing as many components of relapse prevention as possible.

1.3.1.2. Integrating CBT with Dialectical Behavioural Therapy

Dialectical Behavioural Therapy (DBT) is intended to improve the way that a person lives their life while teaching them skills to manage cognitions and behaviours (Thakker & Ward, 2010). This therapy shares a similar perspective of psychopathology and treatment as the Good Lives approach (Thakker & Ward, 2010). Only recently, has DBT been adapted to treat offenders and research into its effectiveness is ongoing (Schaffer et al., 2010). Recent studies indicate that DBT is an effective treatment for violent offenders among intellectually disabled offenders (Sakdalan, Shaw, & Collier, 2010) and violent psychiatric patients (Evershed et al., 2003). For example, a US study of violent psychiatric in-patients (Evershed et al., 2003) found that DBT significantly improved treatment gains when compared to a treatment as usual group. They also found that this treatment reduced the intensity of violence used but not the frequency of its occurrence. The participants in the DBT group reported that they were better able to manage the experience of anger and had reduced their expression of anger.

1.3.2. Emotional Regulation

It is inevitable that people will eventually experience negative emotions so teaching skills that allow them to manage appropriately these emotions is important (Day, 2009; Howells et al., 2004). *Emotion Regulation* is any attempt

by the individual to either consciously or unconsciously influence when and how they experience or express a particular emotion and what that emotion is (Gross, 1998). Emotion regulation can apply to the management of the experience or expression of either positive or negative emotions (Gross, 1998). Emotion regulation can occur through avoiding or modifying situations, changing attentional focus or appraisal, or modifying the physiological or behavioural response (Gross, 1998). These strategies can be used to manage emotion either before or after its occurrence (Howells & Day, 2006). Emotion regulation is an important treatment goal as a lack of emotional regulation can reduce an individual's cognitive capacity to problem solve, resulting in inappropriate behaviour (Day, 2009; Howells et al., 2004).

1.4. Summary

Past research indicates that there are a number of antecedents to criminal behaviour including poor emotional regulation (e.g., Howells et al., 2004) and cognitive distortions that help maintain criminal behaviour (e.g., Marshall et al., 2009). Criminal behaviour is often an attempt to meet basic needs when the person knows of no other way to meet these needs (Ward & Stewart 2003a). To reduce an offender's likelihood of committing an offence, therefore, the offender needs to learn alternative ways of achieving these needs (Ward & Stewart 2003a, b). Both CBT and DBT can be used to teach offenders new attitudes, values and beliefs to facilitate a more pro-social lifestyle (Schaffer et al., 2010; Thakker & Ward, 2010).

1.4. Aims & Hypothesis

The aim of the present study was to test the effectiveness of a CBT based group program for violent offenders. Although CBT based the High Violence

Intervention Program (Grey, 2009) also uses DBT techniques. This program is designed to improve the violent offenders' ability to behave and think more pro-socially by addressing cognitive distortions and improving the emotional regulation of participants. At the completion of this program, participants were expected to have an improved capacity to manage their experiences of anger and avoid violence.

It was hypothesised that after completing this program participants would experience less interpersonal hostility and more empathy and be less impulsive than at baseline. Participants were also hypothesised to experience anger less intensely and frequently and be better able to manage their expression of anger at the completion of the program than before.

Chapter 2: Method

2.1. Participants

There were originally ten participants in the group, but one failed to complete all sessions. Pre and post treatment data were available for seven of these participants, but two were excluded due to an excessive amount of missing data. The final sample consisted of five participants aged between 32 and 52 years (M = 43.80, SD = 7.56). All participants were completing sentences for violent offences including violent property crimes, serious assault and murder. The participants were all assessed as having a high risk of future violent offending. Most had long criminal histories and all had served several years in prison.

2.2. Measures

Participants completed a questionnaire package consisting of the State-Trait Anger Expression Inventory-2 (Spielberger, 1999), Psychological Inventory of Criminal Thinking Styles (Walters, 2006), Barratt Impulsivity Scale-11th edition (Patton, Stanford, & Barratt, 1995) and the Interpersonal Reactivity Index (Davis, 1980).

2.2.1. State-Trait Anger Expression Inventory-2

The State-Trait Anger Expression Inventory-2 (STAXI-2; Spielberger, 1999) consists of 57 items, divided into six scales, five sub-scales and an anger expression index derived from two of the five scales. The State-Anger scale measures how intense an individual experiences anger and how much the individual feels like expressing these feelings, when angry. It consists of 15 items (e.g., *I feel like swearing*). Participants responded to these items using a scale of 1 = *Not at all* to 4 = *Very much so*. High scores indicate how intensely

they experience anger. The Trait-Anger scale has 10 items and measures the frequency of experiencing anger over time (e.g., *I am quick tempered*). High scores indicate a tendency to experience anger. The Anger Expression index has 32 items measuring the tendency to struggle to manage the experience of anger (e.g., *I argue with others*). High scores indicate that the individual struggles to manage the experience of anger appropriately. Participants responded to both the Trait-Anger scale and the Anger Expression index using a scale from 1 = *almost never* to 4 = *almost always*.

A previous study provides evidence of the convergent validity of the state-and trait-anger scales and the anger expression index (Culhane & Morera, 2010). Significant correlations have been found in a sample of US university undergraduates between the anger scale of the Novaco Anger Scale and Provocation Inventory (Novaco, 2003) and the STAXI-2 state anger (r = .31), trait anger (r = .75) and anger expression index (r = .68; Culhane & Morera, 2010). The Cronbach's alpha's in a sample of men for state-anger (α = .94), trait anger (α = .86) and anger expression index (α = .76) indicate adequate internal reliability.

2.2.2. Psychological Inventory of Criminal Thinking Styles

The Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 2006) has 80 items and participants respond using a scale of 1 = *disagree* to 4 = *strongly agree*. Although participants responded to all items, only their responses on the ten items of the interpersonal hostility factor scale (e.g., *When it is all said and done, society owes me*) were analysed. High scores on this scale indicate extreme hostility towards others.

Walters (2006) found a positive correlation (r = .37) between this scale and the Psychopathy Checklist-Revised (Hare, 1991) provides some evidence of it convergent validity. Research indicates that this scale has a moderate Cronbach's alpha for males (α = .78; Walters, 2006).

2.2.3. Barratt Impulsivity Scale-11th Edition

The Barratt Impulsivity Scale-11th edition (BIS-11; Patton et al., 1995) has 30 items (e.g., *I do things without thinking*). Participants responded to items using a four point scale, from 1 = *Rarely/Never* to 4 = *Almost Always/Always*. Higher scores reflect higher levels of impulsivity.

Previous research indicates that the impulsiveness subscale of the Eysenck Impulsiveness Scale (Eysenck, Pearson, Easting, & Allsopp, 1985) is correlated with the BIS-11 (r = .63; Stanford et al., 2009) indicating convergent validity. The Cronbach's alpha for a sample of US prisoners (α = .80) indicates adequate internal reliability (Patton et al., 1995).

2.2.4. Interpersonal Reactivity Index

The Interpersonal Reactivity Index (IRI; Davis, 1980) consists of four scales and 28 items. The participants responded to all of the items on this questionnaire, but only their responses to the seven items of the Emphatic Concern scale (e.g., *I am quite often touched by things that I see happen*) were used in analysis. Higher scores on the Emphatic Concern scale indicate more emphatic concern for others. Participants responded to these items using a five point scale 0 = *does not describe me at all* to 4 = *Describes me very well*.

A study of US first year medical students (Hojat et al., 2001) provides evidence of its convergent validity. This study found that there were positive correlations between the Empathetic Concern Scale and the Perspective Taking

(r = .40), Compassionate Care (r = .41) and total score (r = .48) of the Jefferson Scale of Physician Empathy (Hojat et al., 2001). US studies have measured the Cronbach's alpha of the IRI, as indicating adequate internal reliability, in samples of undergraduates (α = .80; Pulos, Elison, & Lennon, 2004) and opioid addicts (α = .82; Alterman, McDermott, Cacciola, Rutherford, 2003).

2.3. Procedure for Assessment and Treatment

Participants completed a questionnaire package just before the commencement of the program and at the end of the program. The High Violence Intervention Program (Grey, 2009) is a 198-hour group program, consisting of seven core modules that are covered in 66 sessions. For the group evaluated in the present study sessions generally occurred three times per week, but occasionally they occurred twice weekly. Each of the sessions were conducted in accordance to the program manual (Grey, 2009), with two facilitators being present during each session. Each of the modules is briefly described below.

Module 1: Introduction (three sessions) – During this module the participants developed a group participation agreement that outlined the expected behaviour of the group. They also learnt to define violence and how violence relates to the CBT model of the relationship between thoughts, feelings and behaviours.

Module 2: Life pathways (nine sessions) – During the module the participants identified how their past has led to them developing and maintaining problem behaviours that contributed to their offending. The participants were given the opportunity to reflect on how they could change their life path to achieve a more pro-social way of living.

Module 3: Offence process (nine sessions) – During the module participants were encouraged to reflect on their decision making, behaviours and feelings before, during and after their offence. They were also encouraged to consider what they have achieved using violence and alternative non-violent ways of achieving the same ends.

Module 4: Pro-social thinking (11 sessions) – During this module cognitive restructuring was used to facilitate the participants challenging their maladaptive thinking styles. In this way, participants are expected to learn to think before they act and to question their thinking. They also learnt how thoughts related to behaviour and they were given the opportunity to consider how their thinking was related to their offending.

Module 5: Managing emotions (15 sessions) – This module made use of DBT techniques to supplement CBT techniques. During the module, participants were taught how to define emotions and the underlying physiological and cognitive reasons that emotions occur. Participants also learnt various strategies to manage difficult or strong emotions, such as anger and anxiety. At the end of this module, the participants were encouraged to think about how emotions were related to their violent offending.

Module 6: Victim awareness (ten sessions) – Participants were first encouraged to think of their own experiences of being a victim and consider what defines a victim. They were then asked to consider the long term and short-term impact of their offending on their victims and the wider community. To achieve these aims participants read and discussed accounts written by victims of crime about the impact of crime victimisation. The concept of victim empathy was introduced and discussed. They completed a number of written exercises that

involved writing about the impact of their crime on their victim, before performing a role-play exploring the thoughts and feelings that their victim may have had.

Module 7: Self-management (nine sessions) - Participants were encouraged to reflect on what they had learnt during previous modules and reflect on how their motivation for change had developed during the program. They then identified healthy lifestyle goals and worked on developing a written plan of how to achieve these goals. This was followed by participants developing a relapse prevention plan that was focussed on participants identifying risky situations and skills and strategies that they could use to help them manage these situations. Participants also completed a support network plan where they identified the sources and types of support that could assist them readjusting to life back in the community.

Chapter 3: Assessment and Results

Table 1 shows the number of participants at particular levels for each variable of interest at both pre and post test, based on self-report data. The results indicate that there were no changes at post-test in the number of participants at each level of Anger State from baseline. For interpersonal hostility, one participant moved from the very high to high range. The results in Table 1 indicate that the there was change in the number of participants at post-test from pre-test for Anger-Trait, Anger-expression, Impulsivity and Emphatic Concern. The results for the first three of these variables suggest that members of the group improved in these areas. As seen in Table 1, two participants reported that they were high for Anger-Trait at pre-test, but none did at post-test. The results in this table also indicate that while two participants reported being high for anger expression, only one did so at post-test. Improvement on anger expression is also indicated by the participant who went from being average at pre-test to being low at post-test. Another result in Table 1 that suggests improvement is that one participant reported being high for impulsivity at pre-test, but none at post-test. Additionally, one participant who reported being average for impulsivity at pre-test was low at post-test. Finally, the results for emphatic concern presented in Table 1 indicate that members felt less Emphatic Concern at post-test than they did at pre-test. As the table shows, only one participant reported having low Emphatic Concern at pre-test, but three reported this at post-test.

Table 1

Number of Participants at Each Level of the Variables of Interest, at Pre-test and Post-Test (*N*=5)

Interpersonal-Hostility	Very High	High	Average	Low
Pre-test	2	1	2	0
Post-Test	1	2	2	0
Impulsivity		High	Average	Low
Pre-test		1	2	2
Post-Test		0	2	3
Emphatic Concern		High	Average	Low
Pre-test		0	4	1
Post-Test		0	2	3
Anger-State		High	Average	Low
Pre-test		3	2	0
Post-Test		3	2	0
Anger-Trait		High	Average	Low
Pre-test		2	2	1
Post-Test		0	4	1
Anger-Expression		High	Average	Low
Pre-test		2	3	0
Post-Test		1	3	1

Chapter 4: Discussion

4.1. Aim & Hypothesis of the study

4.1.2. Aim of the study

The current study was intended to evaluate the effectiveness of providing offence specific treatment to violent offenders using a group intervention program. This program had been designed to improve the ability of participants to manage their experiences of anger and avoid violence, as well as increasing their empathy towards others. To fulfil this aim several hypotheses about this program were proposed to test if the program did encourage more pro-social attitudes, thoughts and behaviours among the participants.

4.1.2. Hypothesis 1

The hypothesis that participants would experience less would be less interpersonally hostile, more empathetic and less impulsive after completing the program than they did at beginning was partially supported. The results of the present study indicate that participation in the program resulted in no change in interpersonal hostility, less empathy and less impulsivity among participants. Although there was one less participant in the very high range for interpersonal hostility at post-test than at pre-test, there was one more participant in the high range at post-test. A person with a very high or high score on this variable would experience a substantial amount of interpersonal hostility. This result, therefore, indicates that interpersonal hostility remained a problem area for the same number of participants at the end of the program, as it did at the start.

There was, however, the unexpected result that more participants felt less empathy at the end of the program than did at the beginning of the program. This result indicates that the number of participants with low emphatic concern

increased from one at pre-test to three at post-test. It is possible that some participants over estimated their level of emphatic concern at pre-test, due to a lack of insight into their functioning in this area. Another explanation is that this result fits with a pattern that has been found in other treatment evaluation studies. Past studies that have used multiple assessment points have found that mid-treatment gains were higher than post-treatment gains, but at follow up these gains were higher than at mid-treatment (Evershed et al., 2003). This pattern has been explained as possibly resulting from increased anxiety among participants about their capacity to manage, immediately after completing a program, without the support of a therapist (Evershed et al., 2003).

In contrast, none of the participants reported impulsivity, as indicated by high score, as being a problem area at the end of the program. One participant had reported a high score at baseline. Another indication of improvement was that one of the participants who reported being average for impulsivity at pre-test reported being low at post-test. Theorists have argued that offenders tend to behave impulsively and that this behaviour is maintained by cognitive distortions (Egan et al., 2000; Ross et al., 1988). CBT is considered an effective treatment of these cognitive distortions as it addresses how an individual appraises their environment (Egan et al., 2000; Howells et al., 2004; Ross et al., 1988; Schaffer et al., 2010). One of the key aims of Module 4 of the HVIP group intervention (Grey, 2009) is to encourage participants, using CBT techniques, to think before they act.

4.1.3. Hypothesis 2

The hypothesis that participants would experience anger less intensely and frequently and better manage their expression of anger after the program

than before was partially supported by the results. The number of participants that reported high levels of anger state did not change from three. This indicates that completion of the course did not alter how intensely participants tended to experience anger. This result is inconsistent with results of the study by Blacker et al. (2008). These researchers found a significant difference between pre- and post-treatment scores on the state anger scale of the STAXI-2. However, the CBT program they evaluated made extensive use of drama therapy. Although the HVIP intervention (Grey, 2009) includes some role-playing exercises, these exercises only occur in a small number of sessions, so this program may not be comparable to the one evaluated by Blacker et al. This result is consistent with Evershed et al.'s (2003) study that found no significant change in anger state scores among violent psychiatric in-patients after treatment with DBT.

The results of this study indicate that the group improved on trait-anger and anger expression. This improvement is indicated by two participants who reported high level of trait-anger before the program did not do so at the end of the program. Another indication of improvement was that one of the participants reported being high on the anger expression index at the beginning of the program reported being average at the end of the program. Additionally, another participant improved on anger expression by moving from average at pre-test reported to low at post-test. As emotions are known antecedents to criminal behaviour (Day, 2009; Howells et al., 2004; Marshall et al., 2009; Schaffer et al., 2010), providing offenders with new skills to improve their emotion regulation is considered to be an important treatment target (Day, 2009; Howells et al., 2004). By providing offenders with these new skills, they are given an opportunity to overcome the barriers that previously facilitated anti-social lifestyles (Ward &

Stewart, 2003b). Both CBT and DBT are designed to facilitate improved emotional regulation (Schaffer et al., 2010; Thakker & Ward, 2010). These results of the current study are consistent with previous research evaluating CBT based programs for offenders that have found significant post program reductions in trait anger and the anger expression index on the STAXI-2 (Blacker et al., 2008; Mela et al., 2008). The current result is consistent with a previous study that found that violent psychiatric in-patients had significantly lower trait anger scores after treatment with DBT (Evershed et al., 2003).

4.2. Limitations

The results of the current study must be considered in the context of several limitations. This study measured the variables of interest once after the conclusion of the program. An additional measurement time several months after the end of the program may have revealed greater treatment effects. As overall program treatment affects were measured in the current study, it is not possible to determine the specific components of the program that influenced these treatment outcomes. The small sample size also prevented the use of inferential statistical analysis that would have been able to indicate how statistically significant the noted changes were. Such an analysis would have allowed the calculation of an effect size that could help determine the clinical significance of these changes.

4.3. Conclusion

The current study provides some evidence that the HVIP program is effective in improving the prisoners' capacity to manage how they react to anger and the frequency that they experience it, but not how intensely they experience it. The results also indicate that the program was somewhat successful in

encouraging participants to think before they act. It is unclear from these results the impact that the program had on the participants' ability to feel empathy towards others. Measurement at a later date may have clarified whether the unexpected result of the participants feeling less empathy was due to anxiety about the end of the program or more realistic assessment of level empathy at post-treatment than at pre-treatment.

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Placement Report 4

Ethics and Professional Practice Issues Essay

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Abstract

Clinical psychology is a specialist area within psychology that is mainly concerned with providing psychological services to people with mental health issues. The aim of this paper was to discuss ethical and professional issues that I encountered during my training in this area of psychology. Informed consent, confidentiality, competency and termination of the therapeutic relationship were all ethical issues that I experienced while I was on placement. In addition to these ethical issues, I also encountered the professional issues in relations to supervision and the Scientist-Practitioner Model. Over the course of my placements, I learnt a number of different strategies to mange these ethical and professional practice issues, and how to deliver psychological services to clients in an ethical and professional manner.

Chapter 1: Introduction

1.1. Clinical Psychology

There are many different specialist areas within the profession of psychology, including clinical psychology (Australian Psychological Society, 2009a). This specialist area of psychology is mainly concerned with the assessment, diagnosis and treatment of mental disorders and psychological problems (Australian Psychological Society, 2009b). It is in this area of psychology that I am undergoing my training. Currently, to practice as a psychologist in Victoria it is necessary to adhere to the Australian Psychological Society's *Code of Ethics* and be registered to practice by the Psychology Board of Australia (Australian Psychological Society, 2005; Psychology Board of Australia, 2011a, 2011b). For my first three placements my registration was administered by the Psychologists Registration Board of Victoria (Psychologists Registration Board of Victoria, 2005), but for part of my third placement and for my last placement this registration was administered by the Psychology Board of Australia (Psychology Board of Australia, 2011b). The aim of the registration board and the ethical guidelines are to maintain standards that ensure the professionalism of psychologists and protect both the profession and the public from harm (Australian Psychological Society, 2007; Australian Health Practitioner Regulation Agency, 2011).

1.2. Codes of Conduct

Both the Australian Psychological Society's (2005) *Charter for Clients of Psychologists* and the Psychologists Registration Board of Victoria's (1997) *Code of Behaviour for Psychologists* provide standards regarding the way that these organisations expect psychologists to interact with their clients. These

standards are in keeping with the *Code of Ethics* (Australian Psychological Society, 2007). As part of my training, I became very familiar with these standards and I began to learn how to apply them in practice (Psychologists Registration Board of Victoria, 2005).

1.3. Aim

In this paper, I will discuss a number of ethical and professional issues that I experienced during my placements. These issues are discussed in the context of the relevant guidelines. The ethical issues that affected me the most during my time on placement included gaining informed consent, confidentiality, competency and termination of the therapeutic relationship. In addition to these ethical issues, I experienced a number of professional issues on placement, related to supervision and the scientist practitioner model.

Chapter 2: Ethical Issues

2.1. Code of Ethics

The Australian Psychological Society (2007) published its *Code of Ethics* to provide both those working in the profession and the public with a clear understanding of what defines ethical practice in psychology. This code aims to promote ethical principals by providing a specific set of standards regarding ethical behaviour. It also outlines how psychologists are expected to interact with clients, peers and the community.

2.1.1. Ethical Issues Discussed

The ethical issues discussed in this paper, specifically informed consent, confidentiality, competency and termination, were the ethical issues that affected me the most during my time on placement. All of these issues relate to the general principles outlined in the Code (Australian Psychological Society, 2007), specifically; Respect for the rights and dignity of people and peoples, Propriety and Integrity.

2.2. Informed Consent

2.2.1. Ethical Requirements for Informed Consent

The *Code of Behaviour for Psychologists* (Psychologists Registration Board of Victoria, 1997), the *Code of Ethics* (Australian Psychological Society, 2007) and the *Charter for Clients of Psychologists* (Australian Psychological Society, 2005), state that clients of a psychologist are entitled to a clear explanation of any psychological services that they will receive before the commencement of this service. The Australian Psychological Society (2005, 2007) specifically mentions that psychologists need the client's consent to perform any service, in advance of that service commencing. Additionally, the

Code of Ethics states that psychologists need to inform their clients in plain language of procedures, risk, confidentiality, record keeping, duration/frequency of sessions and cost of the services they are providing. According to this Code, psychologists are expected to make it clear to the client that their consent can be withdrawn at any time and to provide the client with a clear understanding of the costs and benefits of the services provided.

2.2.2. Informed Consent in Psychological Practice

Informed consent is required in psychology due to the potential for certain psychological services to have life changing implications for the client, especially if these are used by third parties to make decisions regarding the client (Johnson-Greene, 2007). Various commentators have noted that there are no concrete rules regarding exactly how psychologists can gain informed consent from their clients (Barnett, 2007; Pryor, 1997). Commentators differ, however, regarding the amount of effort that psychologists need to make to ensure that their clients understand what they are consenting to (Barnett, 2007; Johnson-Greene, 2007; Wise, 2007).

There is a need to consider the type of psychological service provided, when gaining the client's informed consent (Johnson-Greene, 2007; Pryor, 1997). During my placement at Centrelink, the issues that I had to draw the client's attention to when gaining their informed consent differed depending on the type of service that I was providing. I always explained when meeting a client that information could be disclosed if someone was at risk, there was a court order, they gave consent or in the course of supervision. When explaining these limits of confidentiality, I also mentioned the cost of sessions. However, when I performed counselling services, I also discussed the type of assistance provided

and number of sessions that were likely to be required to perform this service. I also performed a number of single session clinical interviews, to assist Centrelink staff to determine the client's suitability for certain programs and payments. When performing this service, I explained to the clients that unless they agreed to the disclosure of all relevant information to a number of individuals within the organisation and other organisations that worked with Centrelink to provide services, the interview could not proceed. Finally, when I provided intellectual assessments during this placement, I provided client's with information about the length of testing time and the nature and purpose of the test, in addition to explaining confidentiality and cost.

Commentators have argued that informed consent should not be a single event that happens at the start of therapy, but rather it is something that occurs repeatedly through out treatment, to take into account any variations in the services that the psychologist is providing (Barnett, 2007; Fisher, 2008b; VandeCreek, 2008). For example, during my time at Colac Area Health I sought a client's informed consent on a number of different occasions. I first gained her informed consent to disclose intake information for the purpose of counsellor allocation. After she was allocated to me as a client, I gained her informed consent to pursue a particular treatment plan. When I became aware that the number of sessions that we originally agreed to were not likely to be sufficient to achieve her treatment goals, I gained her informed consent for additional sessions. Finally, as treatment termination drew closer I discussed with her how this should occur.

Similarly, it is necessary for the psychologist to gain the client's informed consent about confidentiality at the time of intake and again when disclosure is

about to occur (Fisher, 2008b; VandeCreek, 2008). In this way, clients can decide whether their agreement to release their personal information will benefit them (VandeCreek, 2008). During my time with the University of Ballarat Clinic, I performed a detailed psychological assessment of a client struggling with university studies. Although I explained confidentiality, the type of testing and use of the information during intake, I went over these issues again after I had explained the results of the assessment to the client. In this way, I was able to ensure that the client was aware of exactly what would be released, how this would occur and if this would benefit them.

Psychologists, however, need to be aware that clients will vary in how much of the provided information they understand (Barnett, 2007; Wise, 2007). When attempting to gain informed consent from the client the psychologist needs to consider the language, developmental level and the cultural background of the client (Barnett, 2007). For example, during my time at Centrelink, I worked with a number of clients with intellectual disabilities. When working with these clients, I simplified my language and explanations and, to facilitate their understanding, I provided them with examples that were more concrete. I also asked these clients if they understood, encouraged them to ask questions, monitored their responses to the services provided and restated/reminded these clients of consent-related issues when it appeared that they did not fully understand.

Another issue related to the client's understanding of informed consent information is the capacity of children and adolescents to make this decision on their own (Jenkins, 2011; Tan, Passerini, & Stewart, 2007). Some commentators have pointed out that the individual's capacity to act autonomously is a skill that

develops with maturity and it can be fostered by allowing children and adolescents to participate in the treatment decision-making process (Jenkins, 2011; Tan et al., 2007). Following this line of thought, the psychologist can take into consideration what the adolescent or child wants from their psychological service, so in this way they can participate in the decision making process without being inappropriately burdened with full responsibility (Tan et al., 2007). During my placement at the University of Ballarat Psychology Clinic, I performed a lengthy and complex psychological assessment of an adolescent with a history of developmental and behavioural issues. Although I first gained informed consent from his mother, I also made sure that I considered his concerns regarding this assessment. For example, I gave him a number of options regarding how many times per week we met and the length of each session, allowing him to choose his preferred option.

2.3. Confidentiality

2.3.1. Ethical Requirements for Confidentiality

The *Code of Behaviour for Psychologists* (Psychologists Registration Board of Victoria, 1997) and the *Code of Ethics* (Australian Psychological Society, 2007) mention that it is the responsibility of the psychologist to protect the client's confidentiality, as much as reasonably possible. Moreover, it is only acceptable to breach this confidentiality when the client has given their consent, people are at risk or law requires it. The *Code of Ethics* also states that in the context of training psychologists can divulge details of the client to colleagues, as long as they have the client's consent or the client is not identified. Another provision in the Code is that psychologists should only divulge as much

information about the client to achieve the purpose of this disclosure and only to people that need that information.

2.3.2. Confidentiality in Psychological Practice

Commentators have noted a number of issues regarding confidentiality (Donner, 2008; Fisher, 2008a), including the possibility that clients may withhold information, due to their fear of their psychologist disclosing this information to other people (Donner, 2008; Tan et al., 2007). Additionally, some commentators have noted that the appropriate management of client confidentiality can enhance their autonomy (Donner, 2008) and improve their mental health (Fisher, 2008a).

As psychologists make their clients aware of a number of exceptions to confidentiality, it is possible that client's will withhold information, as they are worried that it may later be released (Donner, 2008; Tan et al., 2007). This was especially the case when performing intake screens for Alcohol and Other Drugs clients, during my placement at Colac Area Health. Many of these clients were made to attend counselling by others, such as family members or because they were in the midst of legal proceedings. Moreover, these interviews encouraged the client to divulge sensitive information, such as making detailed disclosures of substance use. To encourage them to make these disclosures, I took a number of steps to reassure them that their confidentiality would be respected. I explained to these clients that I was gathering this information for the purpose of treatment planning and counsellor allocation. Additionally, I specifically indicated the relevance of gaining certain information when I asked them to disclose this information, such as drug history. Additionally, at the beginning of the interview when I explained the limits of confidentiality, I also explained the purpose of

these limits, such as preventing harm. When explaining these limits I emphasised their right to give and refuse consent, in all but exceptional circumstances. I also made an effort to develop rapport and address any concerns that they may have about the process.

By maintaining the client's confidentiality, the psychologist is acting in a way that promotes the autonomy of the client, develops a trusting therapeutic relationship and protects the client from potential harm due to this disclosure (Donner, 2008). If a situation requires a psychologist to disclose information, they should only disclose as much as required (Donner, 2008). While on placement at Marngoneet Correctional Centre a client made disclosures that created concerns about his mental health, but there was no indication of risk to others or himself. I discussed my concerns with the client and asked for the client's consent to pass on information that could have implications for his mental health to a psychiatrist. I explained to the client that this disclosure would be limited to my concerns about his mental health and would involve passing on a small amount of specific information that the client had disclosed to me. I gave the client the opportunity to express his concerns and nominate any information he did not want disclosed.

Although, I normally never disclosed confidential client information with out consent, there were occasions, however, when I disclosed information without the client's permission due to risk to others. Fisher (2008a) argues that disclosing information to prevent serious harm due to the client's behaviour, not only prevents harm, but also assists the client in recognising inappropriate behaviours and as a result promotes their mental health. During my first placement, along with my supervisor, I attended a meeting with teachers and

carers of an adolescent client that I had been seeing. During this meeting, I became aware that this client was acting violently and erratically towards his carers. Therefore, we disclosed sufficient information about the client, so that those I spoke to were better able to take action to minimise or avoid harm caused by the client's behaviour.

When working with adolescent and child clients maintaining confidentiality is more difficult as parents and children do not always agree on confidentiality (Tan et al., 2007). Adolescents tend to make decisions about confidentiality based on their expectation of the outcome of this disclosure (Jenkins, 2011). They may not disclose certain information, due to being concerned that this information will be passed on to their parents (Jenkins, 2011; Tan et al., 2007). Parents will need to learn some information during the course of treatment and assessment, as they need this information if they are to make decisions regarding their child's participation (Tan et al., 2007). Moreover, there may be a number of agencies working with a child, such as a school, who may need to know certain information about the child in order to provide a service to the child (Tan et al., 2007).

Due to these issues, it is useful to reassure the adolescent client about confidentiality (Jenkins, 2011). I was confronted with these issues during my first placement at the University of Ballarat Psychology Clinic, when performing a psychological assessment on an adolescent at the request of his school. At the beginning of the assessment and before releasing the final report, I made sure that I discussed confidentiality with the client's parents. I encouraged them to express any concerns that they may have and I discussed the information that would be released, so that they knew what would be in the report. I also

discussed and explained confidentiality, as much as developmental level allowed, with the adolescent client and asked him to express any concerns that he had. I only released information in the report that was necessary to answer the referral question.

2.4. Competence

2.4.1. Ethical Requirements for Competence

Psychologists need to be competent in the services that they provide, according to the *Code of Behaviour for Psychologists* (Psychologists Registration Board of Victoria, 1997), *Charter for Clients of Psychologists* (Australian Psychological Society, 2005) and the *Code of Ethics* (Australian Psychological Society, 2007). Further, these guidelines also state that it is the responsibility of the psychologist to maintain their skill and knowledge levels, so that they can practice competently (Australian Psychological Society, 2007; Psychologists Registration Board of Victoria, 1997). The psychologist is also ethically responsible for ensuring that their professional practice in specific areas is competent (Australian Psychological Society, 2007).

2.4.2. Competence in Psychological Practice

Ensuring that psychologists practice in a competent fashion is a way of protecting the public from harm (Belar, 2009; Kaslow et al., 2009) and ensuring the effectiveness and quality of health related interventions (Belar, 2009). Competence in psychology includes being able to select the correct diagnosis and intervention and to maintain rapport as well as appropriate use of clinical decision-making (Belar, 2009). Pryor (1997) argued that consulting with more experienced clinicians was essential in ensuring that a psychologist was acting towards clients in an appropriate fashion. The *Code of Ethics* (Australian

Psychological Society, 2007) indicates that a psychologist can collaborate with other professionals, as long as confidentiality requirements are being met and that it is in the best interest of the clients.

Due to my lack of experience, I often sought the opinion of my supervisors or more experienced colleagues, to ensure that my clinical decision-making was appropriate. For example, during my time at Centrelink and at the University of Ballarat Clinic, before I submitted a report on a client, I consulted with my supervisor to ensure that the information it contained was appropriate. Additionally, when I was at Centrelink and Colac Area Health I sought consultation from more experienced colleagues before talking to other professionals about the client, such as Doctors. During my time at these two placements and Marngoneet Correctional Centre, I also sought consultation around issues of risk assessment. For example, when performing intake screens for Alcohol and Other Drugs clients at Colac Area Health, a number of clients reported psychiatric histories or suicidal thoughts. I would consult with other clinicians within the Alcohol and Other Drugs team to determine if I needed to consult with mental health services or take any other steps to deal with this situation. Suicide is an area in which adequate supervision is required if those undergoing clinical training in psychology are to become competent in this process (Rudd, Cuckrowicz, & Bryan, 2008).

2.5. Termination of Psychological Services

2.5.1. Ethical Termination of Psychological Services

Another issue covered by the *Code of Ethics* (Australian Psychological Society, 2007) is the psychologist deciding that there is a need to terminate the therapeutic relationship with the client. According to the code, the Psychologist

is expected to do this when they think that the client is not benefitting from their services or they are no longer able to continue working with the client due to a lack of competency or capacity to do so. In these circumstances, it is expected that the psychologist will explain to the client the reasons for terminating the therapeutic relationship and offer the client an appropriate referral to another service provider. The psychologist is also expected to take into consideration the welfare of the client and the client's capacity to pay for another service. There is also a need to explain the limits of confidentiality and to explain to the actual client the limits of their situation.

2.5.2. Termination of Services in Psychological Practice

According to Younggren and Gottlieb (2008), *termination* occurs when the professional relationship between the psychologist and their client ends. Further, the nature of the reason for the termination, the length of this professional relationship and the type of psychological treatment used affect the way that the psychologist should handle this termination process (Younggren & Gottlieb, 2008). Termination tends not to be much of an issue, when mutually agreed to treatment goals are reached (Younggren & Gottlieb, 2008). For example, during my time at Colac Area Health I terminated a relationship with a client as her treatment goals had been completed. When there was only a few sessions left, I began talking to the client about this imminent termination and discussed how it would occur to ensure appropriate closure.

Termination is more difficult to manage when premature termination occurs due the behaviour of the client towards the psychologist or therapy, limitations in the extent that the psychologist can help or a change in the circumstances of either the client or psychologist (Younggren & Gottlieb, 2008).

During my placement at Centrelink, I was forced to cease seeing a client after six sessions as this was the maximum number of sessions allowed under the funding arrangements that this client utilised to access therapy. I told this client during the first session about this funding arrangement and when the number of sessions was reached, I gave him the contact details of another suitable counselling service. Towards the end of my placement at Colac, I terminated my clinical relationship with two mandated clients, due to their lack of engagement in counselling. I offered the clients the opportunity to indicate if they thought they would benefit from more counselling. I also informed these clients that I would inform their referrer of this decision and the reasons for it, as well as providing these clients with feedback about their behaviour in counselling and the outcomes of it.

Additionally, Younggren and Gottlieb (2008) mention that record keeping about termination needs to be adequately kept, so that there is sufficient information for the reader to understand the reason for termination and that the psychologist has acted ethically. They argue that notes that are more detailed are required when there is a pre-mature termination of services as the client may not want the service terminated and are more likely to make a complaint. Whenever I terminated my relationship with a client while on placement, I gave the reason for this termination. I made sure that those who may read the file would have an understanding of the reason for terminating the service.

2.6. Summary of Ethical Issues

During my time on placement I was guided by the *Code of Ethics* (Australian Psychological Society, 2007), *Charter for Clients of Psychologists* (Australian Psychological Society, 2005) and the Code *of Behaviour for*

Psychologists (Psychologists Registration Board of Victoria, 1997). I followed these guidelines to ensure that I provided services to clients in a manner that minimised harm to these clients. Some of the ethical concerns that I experienced while on placement were informed consent, confidentiality, competence and termination. To ensure that I behaved in an ethical manner, I tried to ensure that clients were provided with information in a way that they would understand issues surrounding consent, confidentiality and termination. These discussions with clients also provided the client with the opportunity to raise any concerns that they may have about these issues or ask questions to improve their comprehension of these issues and possible outcomes. I also consulted with my supervisor and experienced colleagues to ensure that I was making appropriate decisions and practicing in an ethical manner.

Chapter 3: Professional Practice Issues

3.1. Professional Practice Issues Discussed

During my time on placement, there were a number of professional practice issues that I encountered. The two professional practice issues that were of particular importance in guiding how I practiced while on placement were supervision and the Scientist-Practitioner Model. These two professional practice issues and how they affected me while on placement are discussed in more detail below.

3.2. Supervision

3.2.1. Supervision Guidelines and Ethics

Under both state and federal registration schemes, I could only practice as a provisional psychologist while I was under suitable supervision that was approved by the respective registration boards (Psychologists Registration Board of Victoria, 2005; Psychology Board of Australia, 2011b). The *Code of Ethics* (Australian Psychological Society, 2007) outlines ethical requirements for supervision, including that supervisors should ensure that supervisees are practicing ethically, within their competence and to ensure that the supervisee develops the skills necessary to practice psychology. The *Code of Ethics* also requires that supervisees not disclose personal information unless they give consent and such a disclosure is a necessary part of training. The *Code of Ethics* also mentions that supervisors are to avoid dual relationship with supervisees. For this reason, the *Guidelines for Supervision* (Australian Psychological Society, 2008) cautions supervisors should not provide therapy to the supervisee. Ultimately, the Supervisor is expected to determine if the trainee is suitable to enter the profession, having reached a satisfactory level of competence

(Australian Psychological Society, 2008). The guidelines advises supervisors to alert the supervisee of any issues that affect the competency of the supervisee as these issues occur rather than at a time of evaluation (Australian Psychological Society, 2008).

3.2.2 Supervision during Placements

It is possible that there will be differences between supervisor and supervisee on issues such as therapeutic orientation (Gross, 2005). One study found that supervisors were reluctant to impose their personal preferences or style of conducting a therapy session, as this feedback was considered subjective (Hoffman, Hill, Holmes, & Freitas, 2005). When on placement at Colac Area Health my Cognitive-Behavioural Therapy orientation conflicted with the psychodynamic approach of my field supervisor. My supervisor however allowed me to use the therapeutic approach that I felt most comfortable with. Often when this supervisor provided suggestions on working with clients, they focused on issues such as rapport building, formulation, treatment planning and progress, organisational requirements, drawing histograms and ethical issues. None of these issues was dependent on a particular style of therapy.

Managing any conflict between a supervisor and myself was important, as research in the US indicates that supervisees often feel hurt and confused after conflicts with their supervisor (Nelson & Friedlander, 2001). These conflicts could lead to the supervisee losing trust in their supervisor, feeling less confident and less professional (Nelson & Friedlander, 2001). The results of another US study (Grey, Ladany, Ancis, & Walker, 2001) found that when supervisors behaved or responded in a way that the supervisee found counterproductive the relationship between supervisor and supervisee, at least temporarily, was

damaged. The occurrence of a counterproductive event, according to these results, often led to a change in the way that the supervisee approached supervision. This change in approach could result in the supervisee being less willing to disclose information and be more guarded, both of which could potentially undermine client care.

During my time on placement, there were occasions that I did not agree with or understand some feedback that supervisors provided. I tended to resolve this issue by asking questions of the supervisor to understand their opinion better. On some occasions, I debated the point with them, but strived to do so in a way that was respectful. Over time, I noticed that I preferred some supervisors to others and my level of comfort in discussing certain issues varied from one supervisor to the next. These preferences tended to develop over time depending on how the supervisor responded and communicated during supervision sessions. I did find, however, that generally I had little difficulty approaching supervisors about clinical issues or being honest about my behaviour while on placement.

In their study of conflicts between supervisors and supervisees, Nelson and Friedlander (2001) found that role conflict and confusion played a significant part in these conflicts. Both the supervisor and the supervisee can act in multiple roles during a supervisory relationship (Australian Psychological Society, 2008; Nelson & Friedlander, 2001). The supervisor often fills the roles of 'mentor' and 'evaluator' simultaneously (Australian Psychological Society, 2008). Similarly, the supervisee on a clinical placement as part of a post-graduate degree performs the multiple roles of therapist, student and subordinate (Nelson & Friedlander, 2001). The first of these roles allows the supervisee to exercise authority when

dealing with clients, the other two roles places supervisees in a less powerful position when dealing with their supervisor (Nelson & Friedlander, 2001).

Role conflict was an issue for me while I was on placement, as I was aware that the field supervisors that provided guidance to me while on placement were also evaluating my competency. Despite this, I made an effort to be honest and forthright during discussions of my clinical skills, as I considered this the best approach to facilitating my development and learning of clinical skills. I also received supervision from a supervisor that was also acting as one of my lecturers and as the course coordinator of my course at the time, they were providing me with supervision. This potential role conflict did not create any difficulties, as all of these roles being performed by this supervisor were related to my training in clinical skills. Additionally, when I met this supervisor for supervision I only discussed clinical issues that occurred during my time on placement or course requirements directly related to the placement.

The Australian Psychological Society (2008) suggests in the *Guidelines for Supervision* that it is sometimes useful or required for the supervisee to have more than one supervisor (Australian Psychological Society). While on placement at Colac Area Health, I was receiving supervision from three different individuals. I was receiving supervision from a clinical supervisor at the university, as well as a field supervisor and a director of counselling services at the work site. This arrangement did not create confusion for me, as a supervisee, as each of the supervisors was providing supervision in different areas. The counselling director provided supervision around working in a community counselling service and general organisational requirements, while the field supervisor provided supervision around my work with specific clients. The

clinical supervisor provided me with supervision around issues relating specifically to the field of clinical psychology and ensured that I was developing competency in this area of psychology. During this placement, the clinical supervisor also provided supervision to both the field supervisor and the director of counselling. Past research indicates that when both the supervisor and the supervisee are being supervised by a more senior supervisor there is potential for confusion about which supervisor has the most authority (Nelson & Friedlander, 2001). This, however, was not an issue for me during this placement, as the clinical supervisor was not involved in case allocation and other decisions involving the day to day running of this clinic.

Supervisors do, however, differ in their expectations of supervisees, their communication style, structure of supervision, interpretation of boundaries in supervision and the amount of time available for supervision (Gross, 2005). When beginning a placement I attempted to develop an understanding of what the supervisor expected from a supervisee during that placement. I also attempted to gain an understanding of the supervisor's approach to supervision and the length, frequency and format of supervision. The supervisors during my time on placement also varied in terms of how much time they had available to supervise me. All of my supervisors, however, provided me with an adequate amount of supervision time, but there were occasions when supervisors went on leave or were not available during a crisis. On these occasions, I was fortunate enough to have access to other psychologists, or experienced individuals from related fields such as social work, working for the organisation that I was on placement with. Having experienced clinicians other than a supervisor was a beneficial feature of my placements at Centrelink, Colac Area Health and

Marngoneet Correctional Centre. In this way if I felt I needed guidance to ensure client safety or welfare, I could receive this even when my supervisor was not at the work site.

3.3. The Scientist-Practitioner Model

3.3.1. Origins and Definition of the Scientist-Practitioner Model

The Scientist-Practitioner Model was developed during the Boulder Conference in 1949 and represented an attempt to create uniform standards for doctorial training programs for psychologists in the US (Baker & Benjamin, 2000). This model represents an effort to integrate the practice of psychology with its scientific basis (Belar & Perry, 1992; Jones & Mehr, 2007). In this way, the practice of psychology is expected to be informed by both research studies and scientific principles (Belar & Perry, 1992). Training programs are designed so that practitioners learn the scientific basis of psychology and related fields that contribute to this knowledge base, as well as provide the practitioner with the skills and attitudes to put this knowledge into practice (Belar & Perry, 1992; Jones & Mehr, 2007).

3.3.2. The Integration of Science and Practice

It can be difficult to implement the scientist-practitioner model during clinical practice (Maddox & Riso, 2007; Overholser, 2010). Moreover, practitioners are not solely reliant on scientific knowledge or skills, as practitioners of psychology are also reliant on interpersonal skills that are informed by cultural knowledge and ethical considerations (O'Gorman, 2001). The scientific component of the model, when applied to psychological practice, involves more than reading studies or performing research, as it includes the application of scientific skills or attitudes (Maddox & Riso, 2007; O'Gorman,

2001; Overholser, 2010; Peterson, 2007). Gathering data and observing and making inferences about clients, as well as hypothesis testing and formulation are examples of scientific skills that are useful clinical skills (Maddox & Riso, 2007; O'Gorman, 2001; Peterson, 2007). For example, during my time on placement, when developing formulations of the client's presentation, I developed a number of hypotheses. By testing these hypotheses, I was able to determine the merits of this formulation and whether it needed to be modified or reconsidered.

These scientific skills are also useful for the evaluation of treatment suitability and outcome (Jones & Mehr, 2007; Maddox & Riso, 2007; Mellot & Mehr, 2007; Peterson, 2007; Sauer & Huber, 2007; Vespia & Sauer, 2006; Wolfe, 2007). Reimbursement from funding agencies is often based on the use of evidence supported treatment (Mellot & Mehr, 2007; Wolfe, 2007). For practitioners to be able to evaluate what is and is not effective treatment they need the knowledge and skill to be able to evaluate the outcomes of research (Jones & Mehr, 2007; Peterson, 2007), including determining if the treatment is suitable for a particular population (Peterson, 2007). When implementing interventions, I checked the suitability of these interventions for the client that I was working by reading journal articles or treatment guidelines that were research derived. I based my judgement on implementing a certain intervention on evidence that it worked for the population that the client came from and if there was evidence that it worked with the presenting issues that the client had. I also needed to consider non-scientific considerations, such as whether it was ethical to implement a particular intervention (O'Gorman, 2001). Ethical considerations I needed to keep in mind were my competency in implementing a

particular interventions and the willingness of the client to undergo the intervention.

Practitioners also require scientific skills to evaluate client progress and the effectiveness of treatment (Jones & Mehr, 2007; Vespia & Sauer, 2006). They need to gather outcome data using psychometrically sound measures (Maddox & Riso, 2007; Sauer & Huber, 2007). I relied on my observation of the client to determine their level of comfort with and understanding of a particular intervention. Although, I made use of pre-test and post-test measures as ways of measuring outcome, I also relied on the client's subjective appraisal of outcome and my own observations of changes, if any, in their presentation.

3.4. Summary of Professional Practice Issues

The Scientist-Practitioner Model was developed to ensure that the science of psychology was integrated with its practice (Belar & Perry, 1992; Jones & Mehr, 2007), but it can be difficult to implement into practice (Maddox & Riso, 2007; Overholser, 2010). In order to fulfil the expectations of this model, I made an effort to apply scientific thinking and skills to my clinical practice. This included gathering and interpreting data from the client, testing hypothesis, making decisions about the suitability of treatment and evaluating the effectiveness of treatment.

Supervision is another important component of training in psychology. Supervisors are responsible for ensuring that supervisees practice competently and ethically (Australian Psychological Society, 2008). There were a number of issues relating to supervision that could affect the supervisory relationship. These issues included individual variation among different supervisors in time available and content of supervision, as well as the need to manage disagreement

between the supervisor and myself. During my time on placement, I was aware of these issues and they did affect my relationship with different supervisors. As I had a number of different supervisors, I had to develop ways of managing interactions with supervisors to ensure that I was able to learn from supervision sessions and develop as a clinician. These strategies included being aware of the supervisor's expectations and style, making appropriate disclosure about my clinical practice, responding to feedback and asking for clarification when not understanding this feedback.

3.5. General Conclusion

The *Code of Ethics* (Australian Psychological Society, 2007), the Scientist Practitioner Model and supervision are all intended to ensure the quality of services provided by psychologists to the public (Australian Psychological Society, 2007, 2008; Jones & Mehr, 2007). During my placements, I had to mange a number of different ethical and professional practice issues. In doing so I developed an understanding of how to deliver services to clients in an ethical and professional manner.

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